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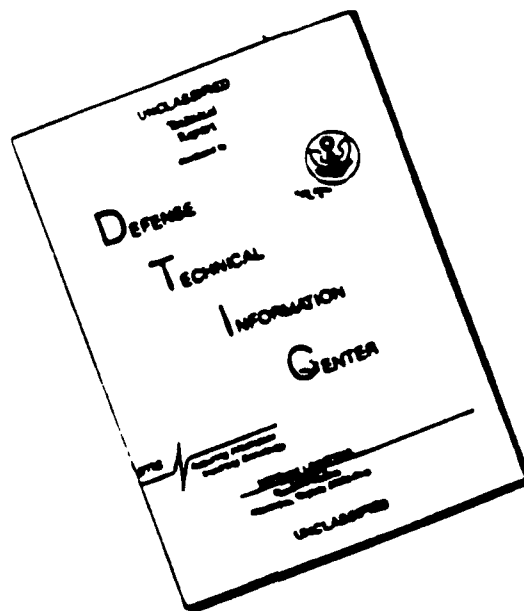
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THE FORT BRAGG MENTAL HEALTH DEMONSTRATION PROJECT

A Graduate Management Project  
Submitted to the Faculty of  
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In Partial Fulfillment of the  
Requirements for the Degree  
of  
Masters of Health Administration  
by  
Captain David W. Howe  
July 1992

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**The staff of the Rumbaugh Mental Health Demonstration  
Project and the North Carolina Division of Mental Health,  
Developmental Disabilities and Substance Abuse Services**

## ABSTRACT

In this paper I will analyze the importance of an effective Contracting Officers' Representative (COR) surveillance plan for managing a coordinated care program. The surveillance plan I will use as an example is the plan for the Fort Bragg Mental Health Demonstration Project. The purpose of the demonstration project is to improve the quality of mental health care for children of military families for less cost than care from the Civilian Health and Medical Program of the Uniform Services (CHAMPUS).

While the formal surveillance program did not begin until after the contract entered its second year of operation, once the COR began using the surveillance plan positive results occurred. The major accomplishments of the surveillance program were identifying problems in the quality of patient care and questions about the cost effectiveness of the project. The contractor and the independent evaluation team dispute the findings of the COR. This disagreement highlights the criticality of having indisputable standards upon which the surveillance plan is based.

The key to a successful coordinated care contract is to have a well thought out and aggressively executed surveillance plan.

## AUTHOR'S NOTE

My Graduate Management Project (GMP) focuses on the criticality of contract surveillance for any government managed care contract. I selected the Army's Mental Health Demonstration Project at Fort Bragg as the case study for analyzing contract surveillance. Contract surveillance, by its very nature, looks for things that are wrong. As a result, my research on the importance of contract surveillance will show problems, some of them very serious, with the Demonstration Project. Due to my narrow focus on the project it is essential for the reader to avoid judging the success of the entire project on the basis of the research presented in this paper. Clearly, it is far beyond the scope of my paper to determine the degree of success of the Demonstration Project. For those readers who are interested in the official evaluation of the entire project, I included, as Appendix B, the interim report from Vanderbilt University. (Vanderbilt University is under contract to evaluate the entire Demonstration Project to determine the effectiveness/efficiency of the project.)

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## **I. INTRODUCTION**

### **Conditions Which Prompted the Study**

In 1991, the cost of health care had become front page news as exemplified by this excerpt from the Chicago Tribune: health care will cost more than \$756 billion or roughly 12.2% of the Gross National Product (GNP) (Beck, 1991). This compares to 1960 when health care accounted for 5% of GNP (Rowley, 1992). Some projections estimate the U.S. will be spending \$2 trillion on health care by the year 2000 (Rowley, 1992). This enormous expenditure on health services puts a tremendous strain on all segments of American society. For example, United States business's share of the health care costs in 1991 was \$186 billion (Faltermayer, 1992). Obviously, businesses transmit these costs back to the consumer. Many business leaders are citing health care expense as a major factor preventing American businesses from being able to compete with overseas businesses.

The cost of health care is not only a concern for U.S. business leaders but millions of Americans are not able to afford to access the medical system. Experts estimate there are 30-37 million Americans without health insurance and an additional 60 million are

underinsured (Karlin, 1991 and Rowley, 1992). For these and many other reasons the cost of health care has become an item of intense national interest and debate.

The two most talked about solutions are "Nationalizing" the health care industry or adopting the concept of managed health care. The July 29, 1988 edition of Modern Healthcare goes so far as to speculate that, by 1997, HMOs and PPOs will control 80% of the health-care market. Fortune magazine goes even farther by advocating virtually every American should be a member in some form of a managed care plan (Faltermayer, 1992). These two articles highlight the experts in the health care industry belief managed care is the solution for the 1990s.

The Department of Defense (DOD) is also experiencing enormous increases in the cost of providing health care for 9 million eligible beneficiaries (Pasztor, 1991), of which 6.7 million are dependents or retirees (Baine, 1991). In addition, the Department of Defense spends \$14 billion on the entire health care system (Kenkel, 1991a). The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for most of the health care provided to the 6.7 million dependents and retirees. Moreover,

from 1981-1991, the Department of Defense CHAMPUS expense increased from \$852 million to approximately \$4.0 billion (Badgett, 1990 and Kenkel, 1991a).

Dr. Enrique Mendez, Assistant Secretary of Defense for Health Affairs, believes managed care is the solution to the rapidly rising cost of providing health care (Pasztor, 1991). Dr. Mendez has empowered the various services, including the Department of the Army, to implement managed care (Pasztor, 1991).

A prime candidate for managed care is the area of mental health services. At the National level, one survey showed the cost of mental health benefits grew 28% in 1988, which is twice the percentage increase for other health benefits (Edinburg & Cottler, 1990). Moreover, this rate of increase is roughly six times the inflation rate for all goods and services. Currently, employers spend more than 30% of their health care dollars on mental health service, including substance abuse treatment (Belichick, 1991).

The cost of child and adolescent psychiatric services is the leading cause of the increase in mental health care costs. From 1980-1984, the number of children receiving inpatient psychiatric services increased 450%, from 10,764 to 48,375 inpatients (Bickman, Heflinger & Pion, 1991). The cost of

adolescents mental health care increased from \$1.5 billion in 1983 to \$4.0 billion in 1988 (Belichick, 1991). This may only be the tip of the iceberg; some experts believe more than half the children needing psychiatric care do not receive it (Bickman, et al, 1990). Although, other experts believe inpatient adolescent mental health services are the most abused aspect of inpatient services (Belichick, 1991).

In his testimony to Congress, Mr. Baine (1991) highlighted the concern within the Department of Defense that mental health services are a major factor in the continuing increase in CHAMPUS costs. Mental health care accounted for approximately 18% of all CHAMPUS costs in 1984 and that percentage is increasing (Burn, Smith, Goldman, Barth, and Coulam, 1989). From 1985-89, the CHAMPUS cost for mental health services more than doubled to over \$600 million (Byron, 1991). Mental health services for children and adolescents account for roughly 73% of the CHAMPUS mental health expense (Byron, 1991). For example, between 1986 and 1989 the number of admissions for children ages 10-19 increased from 7,500 to 19,288 (Nelson, 1992a). Additionally, according to the American Psychiatric Association, large amounts of money are wasted on psychiatric services because no one is monitoring

patient progress (Belichick, 1991). These facts were central to the Congressional decision to direct the Department of Defense to undertake a child and adolescent psychiatric demonstration project in the Fort Bragg catchment area (Report of the Committee on Appropriations 100-410, 1987).

Lenore Behar, PHD, was the principle proponent of this demonstration project. Dr. Behar is a special assistant for child and family services for the State of North Carolina. The demonstration has three main goals:

1. To demonstrate that an alternative delivery system (i.e., a full continuum of mental health services) can provide quality services to more clients per year for the same cost as for a traditional approach to service provision.
2. To demonstrate that as an alternative, a full continuum of mental health services for children/adolescents can be tailored to the clients' needs and thus provide more appropriate and more cost effective treatment services per client.
3. To demonstrate the efficacy of a federal-state contractual agreement in providing mental health services for military children/adolescents (Behar,

1991).

It is critical to highlight the purpose of the demonstration is to do more than manage care, i.e., provide utilization review and negotiated rates. The central strategy of the demonstration is to offer "less expensive substitutes for the more expensive hospital based care" (Behar, 1992, p.1)

At the heart of any managed care initiative is the contract. An effective contract spells out exactly what is to be managed and how. However, even a well written contract is subject to failure if it is not properly overseen. The key element in overseeing a contract is the surveillance plan. Therefore, this paper will analyze the surveillance aspect of the government (DOD/DOA) contracts with the State of North Carolina to execute this demonstration project. As a result of the analysis on the contract surveillance, I will provide an overview of the essential elements of this demonstration project and some of the lessons learned from this effort to provide managed care to child/adolescent mental health services. Moreover, I will highlight the key elements of the surveillance program which were most helpful in monitoring the project.

### **Statement of the Management Question**

What are the essential elements that make up an effective surveillance program? (Specifically, a contract in which the Army contracts with a state agency to conduct the managed care project through the use of a civilian not-for-profit subcontractor.)

### **Review of the Literature**

Few Americans would argue that there are serious problems with the nation's health care delivery system. One of the main problems is the cost of health care in America. Experts expect health care costs to raise 10.7% this year (Cerne, 1992). This percentage increase will result in Americans spending more than \$817 billion on health care or 14% of the (GNP) (Cerne, 1992). Moreover, the rate of inflation for the health care industry is approximately three to four times the rate of inflation for all other goods and services (Edinburg & Cottler, 1990).

The nation's health care system also has a tremendous problem providing equitable access to health care for all citizens. The access problem is best exemplified by the estimated 34 million Americans without health insurance and another 60 million with inadequate health insurance (Karlin, 1991).

The most recently acknowledged problem is the cost of employees health benefits is eroding U.S. companies' ability to compete in the world market place. Overall, employers are paying 20-30% more each year for their employees' health care plans (Edinburg & Cottler, 1990). In 1989, spending for health services as a percent of corporate after-tax profits grew to more than 100% (Karlin, 1991). So, American businesses share of the health care bill for 1990, \$186 billion, exceeds their after-tax profits (Faltermayer, 1991). "Moreover, the average cost of health coverage went from \$2,600 per employee in 1989 to more than \$3,100 in 1990. At this rate, the average health-care premium will be more than \$22,000 per worker by the year 2000" (Karlin, 1991, p. 1). While there are many other problems with the U.S. health care system, these three highlight the crisis facing the delivery of health care in America. Experts in the health care industry are betting on the concept of managed care being the solution to this crisis.

Mental health is one of the largest "cash cows" in the health care industry, and therefore, one of the main causes for the crisis in health care. The magnitude of the growth in mental health services is exemplified by this quote, "...Psychiatric hospitals

represented the largest share of market growth for investor-owned systems. The number of psychiatric hospitals increased by 9% from 1986-1987, from 297 to 324 hospitals. During the same period, the number of psychiatric beds jumped 28 percent—from 24,008 to 30,633 beds" (Martinsons, 1988, p. 52). Additionally, "The Commerce Department estimates that expenditures in 1990 for health care services in the United States will exceed \$660 billion, or roughly 12% of the gross national product" (Dorwart, 1990, p. 1088). Dorwart indicates mental health care accounts for 12-14% of that \$660 billion (Dorwart, 1990). "A recent survey of 1600 businesses noted that costs for employee mental health benefits rose 28 percent in 1988, twice the rate of increase for other health benefits" (Edinburg and Cottler, 1990, p. 1063). In firms with more than 5,000 employees, mental health costs grew at more than 47% in 1990 (Mason, 1991). Dr. Borenstein (1990) states the major portion of this increase is attributable to adolescent inpatient care or substance abuse treatment. From 1983 to 1988 the cost of psychiatric services for adolescents increased from \$1.5 billion to \$4 billion (Belichick, 1991). The magnitude of mental health services is exemplified by the fact that in 1988 Chrysler employees spent as many days in the hospital

for psychiatric care as they did for all other medical reasons combined (Longnecker, 1991). This explains the increase in the number of psychiatric hospitals tripling over the past decade (Dorwart, 1990). Clearly, the cost of mental health services is a major determining factor in the overall cost of health care. Thus, mental health services are a prime target for the proponents of managed care.

Managed care is not a new idea. In fact, a large portion of health care is currently provided through some form of managed care system. For example, Dr. Dorwart (1990) says seven in ten Americans find that their health care utilization is managed through some type of managed care program. Estimates show three out of four psychiatric patients will receive their care from some form of managed care program (Dorwart, 1990). One of the major reasons for the switch to managed care programs is cost savings. Due to a lack of programs to monitor psychiatric patient care large amounts of money are wasted (Belichick, 1991). For example, HMOs hospital reimbursement rate is roughly 40% less than a traditional indemnity plan (Kenkel, 1988). This trend highlights what several studies are suggesting: managed care is a more profitable way to do business. In 1989, Hospitals

magazine published a study which indicated that "55% of the HMOs surveyed were profitable compared with 32% in 1988" (Managed Care, 1990, P. 22). The author of the Hospitals article goes on to say, "Twenty-two percent of the HMOs expanded benefits in their best-selling plans in 1989, most commonly adding mental health and substance abuse treatment" (p. 22). Improved profits is a major argument for adopting managed care.

To some, this increased profitability is an interesting paradox, given the purpose of managed care is to cut costs. A logical assumption would be reduced costs mean reduced profits. The advocates of managed care would argue that managed care maximizes efficiency, and thus, reduced costs is not a mutually exclusive event from increased profits. In other words, managed care is a win-win situation in which the patients gain by less costly medical care and the providers gain by greater profit margins. For example, in 1988, the year HMOs achieved their largest market penetration, the cost per admission was reduced by \$483 which accounted for a \$1.04 billion annual savings (Kenkel, 1992b).

Given the Assistant Secretary of Defense for Health Affairs mandate to implement the concept of managed care, I will now briefly examine how managed

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care fits the military health care system. It is essential to acknowledge the fact that the military child psychiatric patient population is similar to the civilian population (Pehrson and Lee, 1991). In order to best understand how the concept of managed care fits the military medical system one must understand the basic structure of the DOD health care system. The Department of Defense operates a dual health care system. One element is the direct care system which operates out of DOD treatment facilities and the second element is CHAMPUS. "CHAMPUS is a medical benefit program that cost shares charges for medically necessary treatment provided to eligible beneficiaries by civilian sources when needed services are not available from the military direct care system" (Badgett, 1990, p. 1). One quick look at the amount of money spent on CHAMPUS and it is easy to understand why the military is interested in managed care. In fiscal year (FY) 1981 the Department of Defense spent \$852 million on the CHAMPUS program, by FY 1988 the cost had climbed to \$2.5 billion (Badgett, 1990). The CHAMPUS budget overrun for fiscal year (FY) 1990 was \$740 million (Kenkel, 1991c). Mental health care costs increased 126% between 1986 and 1989 (Nelson, 1992b). In 1991, CHAMPUS expenditures for mental health

services were \$631 million (Nelson, 1992b). The average psychiatric admission costs \$25,563 and the average length of stay is 102 days (Behar, 1991). Add to these figures the emerging opinion that over 40% of all child psychiatric admissions are unnecessary and that over 50% of those admitted could be treated in less restrictive (and less costly) settings (Behar, 1990). Psychiatric services account for approximately 20% of total CHAMPUS expenditures (Burns, Smith, Goldman, Barth, and Coulam, 1989).

One of the many managed care experiments the Department of Defense is pursuing is the CHAMPUS Reform Initiative (CRI). Foundation Health Corporation is the civilian managed care group responsible for administering the health care delivery for all DOD beneficiaries in California and Hawaii. According to researchers at the Rand Corporation, CRI appeared to reduce mental health inpatient expenditures by 17% between 1987 and 1989 (Kenkel, 1991b). This savings reduced the mental health care portion of the CHAMPUS bill from 28% to 22% (Kenkel, 1991b). During the same time period mental health care costs rose 94% in the non-CRI areas (Kenkel, 1991b). One reason for such dramatic savings is the Length of Stay (LOS) is only 10 days for CRI patients versus the average from 1984 of

31 days (Kenkel, 1991b). This reduction in LOS accounts for the drop in the cost per admission from \$18,539 to \$2,515 (Plunkett, 1992). So there is strong evidence to support managed care as a cost effective method of delivering mental health care.

Another managed care initiative the Department of Defense is exploring is the Tidewater Demonstration Project. The Tidewater Demonstration Project is designed to reduce the cost of mental health care in the Tidewater area of Virginia. Initial findings are very encouraging, the project has saved \$140 million (Plunkett, 1992). For example, in May of 1988 there were 110 children in residential care now there are only four (Plunkett, 1992). These figures are good news for everyone concerned with the cost of health care.

Cost is not the only reason to be concerned about mental health care provided to CHAMPUS beneficiaries. Thousands of service members' children are imprisoned in psychiatric facilities (Nelson, 1992a). Nelson (1992b) goes on to state the (LOS) in a mental treatment facility is highly correlated to how many days their insurance will pay for, this is particularly true for children. In fact, the average inpatient length of stay was 35 days for CHAMPUS eligible

patients versus the national average of 13 days (Burns et al., 1989). As of May 1992, there are 52 cases, 43 of which involve treatment of minors, of potentially fraudulent claims for mental health services under investigation by the Pentagon (Nelson, 1992b). Eighty percent of these cases are provider fraud (Nelson, 1992b). Nelson (1992b, p. 3) also cites the findings of a consulting firm which indicates "one-third of hospital admissions for psychiatric care were unjustified and two-thirds of the care did not meet - or couldn't be proven to meet - Defense Department standards".

In Nelson's article (1992b) she highlights a couple of the most serious abuses of CHAMPUS mental health benefits. In one case, a provider was indicted on 74 counts of CHAMPUS fraud; one of the counts is having sex with patients as part of therapy. Another case involves a mother and her four year old daughter being held against their will in a psychiatric hospital in Texas. CHAMPUS fraud is not a new phenomenon. The key to preventing fraud is proper oversight by all levels of the military health care system (Nelson, 1992b).

The Pentagon hired a private contractor to review 137 residential treatment centers (RTC). The

contractor determined 26, or 19%, should be removed from the CHAMPUS list of approved providers (Nelson, 1992b). The situation is so serious Congress has a special committee investigating the problem. The committee chairperson, Congresswomen Patricia Schroeder, described the problem this way, "'Clearly, this business of treating minds - particularly this big business of treating young minds - has not policed itself and has no incentive to put a stop to the kinds of fraudulent and unethical practices that are going on (Nelson, 1992b, p.3).'"

Since 1988, Congress initiated several programs to bring CHAMPUS costs down while improving the quality of care. These programs are designed to decentralize the management of the CHAMPUS budget (Badgett, 1990). The most recent initiative is to allocate all of the CHAMPUS budget to the catchment area hospital commander. This managed care program has four major objectives:

1. Contain the rate of growth in CHAMPUS costs.
2. Improve accessibility to health care.
3. Improve satisfaction with health care.
4. Maintain quality of health care. (Badgett, 1990), p. 3)

Managed care seems to be having the desired effect

in the area of mental health services. Through the use of managed care programs the CHAMPUS expenditure for inpatient psychiatric treatment declined from \$15.9 million in 1987 to \$13.2 million in 1990 (Kenkel, 1991b). This summarizes the argument in favor of managed care.

While the vast majority of experts in the health care industry believe managed care is the solution to the health care crisis, there is growing opposition to the concept of managing medical care. This debate is especially keen among mental health care professionals. The main questions about managed care are: "...whether it adversely affects the quality of care... [and] ...whether it restricts access to care..." (Dorwart, 1990, p. 1087). Dorwart (1990) goes on to hypothesize that it is a myth that managed care, by itself, can control the increase of mental health care costs. According to the Institute of Medicine, utilization management is a one-shot savings, not a continuous cost control (Dorwart, 1990). Moreover, managed care is leading to rationing. In many states that do not have mandatory inpatient benefits, HMOs provide little or no coverage for inpatient psychiatric care (Dorwart, 1990). Dorwart (1990) claims it is a myth that managed care does not affect the quality of care, implicit in

cost reduction is lesser quantity and/or quality. For example, "60% of psychiatrists responding to a national survey reported pressure from outside influences to shorten the length of stay or to discourage treatment for some patients" (Dorwart, 1990, p. 1090).

Another argument against managed care is the cost of utilization management may be greater than the savings (Dorwart, 1990). Some beneficiaries are also against the concept of managed care because some of them have been denied access to treatment. Congress is exploring these concerns on the part of beneficiaries. The dilemma of managed care is how to achieve the goal of insuring high quality mental health services at an appropriate cost while not denying care to needy patients (Nelson, 1992b).

Dr. Borenstein (1990) suggests many of the people conducting psychiatric patient care reviews are not qualified to make such judgements. Even those who are qualified to make judgements about patient care are under such pressure to contain costs they are unlikely to be able to make objective decisions on the appropriateness of treatment (Borenstein, 1990). Dr. Borenstein (1990) also describes a "sentinel effect" in which psychiatric patients refuse or discontinue treatment because they fear a loss of patient

confidentiality due to the requirement for external review.

One final problem with plans to adopt a managed care approach for psychiatric services is psychiatrists control the delivery of psychiatric services. Psychiatrists determine how 70% to 80% of the money used to pay for mental health care will be spent (Patterson, 1990). Due to this fact, managed care programs must have the full support of the psychiatrists in order to be successful. This kind of consensus among psychiatrists may be very difficult to obtain.

The military is a microcosm of the national debate against managed care. Probably the largest DOD managed care program for mental health services is the Tidewater Demonstration Project. Some beneficiaries are accusing the Tidewater Demonstration Project of denying them access to care (Plunkett, 1992). Some of these charges stem from the potential conflict of interest faced by the contractor for the Tidewater project. The potential conflict in interest arises from the terms of the contract. The contract sets a fixed payment amount for the contractor regardless of how much medical care the contractor provides. In other words, the contractor, First Hospital Corporation

(FHC), has a very strong financial incentive to deny treatment (Nelson, 1992a).

Not only is this a potentially harmful situation for the patient but, CHAMPUS can end up paying twice for the same beneficiary. This double paying could occur when a beneficiary in the Tidewater area is denied care by First Hospital Corporation (FHC) and the family obtains care outside the Tidewater catchment area (Nelson, 1992a). In this case, CHAMPUS pre-paid FHC and then has to pay the provider of the care. A spin off of this double billing problem is the possibility that beneficiaries will know to avoid an assignment to the Tidewater area if they have a problem child. The net effect of this situation is the Tidewater area has a lower acuity rating which means it will cost FHC less to provide care (Nelson, 1992a). However, it will cost CHAMPUS more for other catchment areas.

Other beneficiaries in the Tidewater area complain of poor quality of care. In one case, a therapist never asked to see a patient for an appointment, the patient then committed suicide (Plunkett, 1991). Government inspectors find a major problem with the quality of treatment in 20% of the patients (Plunkett, 1992).

Another major argument against the DOD managed care initiatives is the program cost shifts. Because of the CHAMPUS eligibility rules many patients do not qualify for care under the CHAMPUS program. When beneficiaries do not meet CHAMPUS eligibility requirements they must seek care from other governmental agencies. (Currently, the states are the primary payers for mental health services (Behar, 1990.) And needless to say, the states are not thrilled with the prospect of picking up the bill for dependents of military personnel.) For example, CHAMPUS does not cover "custodial care". (Custodial care is defined as the care needed to meet the needs of daily living.) This means a child who is retarded will need to seek care from some other agency, generally, from the state. As a result, states with good mental health care programs become the location of choice for servicemembers with children with chronic problems. So, the state picks up the financial burden of these DOD beneficiaries.

A judge for the state of Virginia claims CHAMPUS eligible beneficiaries are not receiving the care they have a right to from the federal government (Nelson, 1992a). In fact, the state of Virginia has a waiting list of 200 children with psychiatric problems (Nelson,

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1992a). The initial data is still insufficient to alleviate these concerns. However, the preliminary numbers indicate roughly 1% of the patients denied care by FHC eventually receive care outside the catchment area (Nelson, 1992a).

Many believe the Department of Defense does not have the ability to design and operate a managed care system. A report by the General Accounting Office states few hospital commanders have demonstrated the ability to make the managed care program a success (Kenkel, 1991c). This inability of military hospital commanders to operate an effective managed care system lead lawmakers to analyze whether military administrators or civilians should run the military's health care system. Mr. Kenkel (1992a) hypothesizes military administrators do not possess the knowledge to effectively/efficiently run a managed care system (Kenkel, 1992a). Mr. Kenkel (1992a) also highlights the fact that Congress is debating whether to turn the administration of the military health care system over to civilian health care administrators. Even members of the Army Medical Department are on record as saying efforts to manage care through civilian contracts are not achieving the goal of saving money (Jensen, 1989).

Despite the argument against managed care the

nation's health care system is clearly adopting managed care policies. Specifically, Dr. Mendez is convinced coordinated care (Dr. Mendez prefers the term coordinated care to managed care) is the solution to gaining control of the growth in the cost of the DOD health care system. However, it would be wise to be aware of the arguments against managed care in order to avoid those potential problems.

At the heart of any managed care initiative is a contract. According to the American Heritage Dictionary (1988) a contract is: An enforceable agreement; covenant. Obviously, no one enters into a contract with someone who they believe will not live up to their part of the agreement. However, "trust but verify" is the key to a successful contract. Therefore, the most important part of a contract is the surveillance plan to insure all parties live up to their part of the contract.

Negotiation is the first step in contract management. While there are numerous potential pitfalls in negotiating a successful contract, there are four major areas which cause problems. The first thing to remember in negotiating a contract is not to pre-select a vendor (Cerne, 1989). (Congress violated this rule when they pre-selected who would manage the

mental health care project at Fort Bragg.) It is essential for the contract to have well defined deliverables (Simpson, 1991). Another item that is crucial to negotiating a sound contract is the negotiating team must have accurate cost information (Johnsson, 1991). Without accurate knowledge of what it costs to do a procedure in-house versus out-of-house the contract may end up hurting the organization. The last item is insuring the negotiations specify what the "warranty" is (Simpson, 1991). The warranty goes hand-in-hand with the deliverables. In other words, if the contractor fails to meet the standard for a particular deliverable the penalty will be a specific action. The bottomline is all parties need to know exactly what they are suppose to do and what happens if they fail to do so.

The end product of a successful negotiation period is a contract that all parties can support. The next step is the contract execution phase. The length of this step is clearly spelled out in the contract. The essence of this phase boils down to how well all parties meet the conditions of the contract. This step centers around formal criteria developed to detect contract compliance (Remington and Hylton, 1991). It is this verification process that insures all parties

contract needs are being met.

The final step in the contracting process is renewal/termination phase (Korenychuk, 1991). The contract must specifically address both possibilities. Once again, it is essential that all parties have a complete understanding on how the game is to be played and what their responsibilities include. In the case of renewal, the most important aspects are when the contract is due for renewal and if the contractor will need to re-bid to obtain the contract (Korenychuk, 1991).

Termination is a more complex matter. First, the reasons for termination must be defined in such a way that there can be no argument about the justification for one party terminating the contract (Korenychuk, 1991). Terminating a health care contract is not as easy as most contracts. Termination plans must address exactly how patients will receive their care after the contract terminates. In addition, items like disposition of medical records must be planned for prior to the start of the contract (Korenychuk, 1991).

The termination plan should provide the contractor with an opportunity to respond to charges they are not meeting the terms of the contract. When the contract oversight personnel identify deficiencies they need to

clearly articulate the problem to the contractor and indicate a reasonable timeframe in which the deficiencies should be resolved (McLaughlin, 1988). In a worst case scenario, if the contractor continues to fail to meet the standards of the contract the oversight personnel should initiate more frequent reviews (McLaughlin, 1988). Additionally, the personnel responsible for managing the contract should lay the ground work for executing the termination plan.

These contingency plans are easily overlooked during the negotiation phase. However, it is absolutely necessary to work out a comprehensive termination plan as part of the terms of the contract. Through proper planning a bad situation (contract termination) can avoid becoming a disastrous one or even a potentially life-threatening one for those patients receiving care from the contractor. So, the most important part of the contract is how to end it if it is not accomplishing its objectives (Anderson, 1989).

In a government contract, the terms of the contract are described in the Statement of Work (SOW). Therefore, the SOW forms the basis upon which to develop the surveillance plan for insuring the contractor meets the terms of the contract.

### **Purpose of the Study**

The purpose of the study is to determine the major elements essential in developing an effective and efficient surveillance plan for monitoring a coordinated care contract specifically where the government contract involves a state contractor and a civilian subcontractor.

## **II. METHODS AND PROCEDURES**

### **Study Design**

This study will be qualitative in nature. The major aspects of the methodology are: 1) a series of interviews with the key project personnel, 2) review of documents generated by personnel involved in the project, 3) other surveillance systems and 4) additional written sources of information.

The following are the key interviews I conducted with personnel involved in the military contract surveillance program:

1. Colonel Elmer Casey, Commander of Womack Army Medical Center (WAMC), the medical center responsible for the catchment area in which the demonstration is being conducted.

2. Colonel Thomas Whitesell, Chief of Staff, WAMC.

3. Colonel Kevin Kiley, Deputy Commander for Clinical Services, WAMC.

4. Captain Jennifer Douglass, Contracting Officer Representative (WAMC) for the demonstration contract.

5. Major Michael Wymes, Project Officer (WAMC) for the demonstration.

6. Lieutenant Colonel (P) Dennis Dohanos (Health Services Command point of contract (POC) on the demonstration).

7. James Newman, Contracting Officer Representative (WAMC).

The following are the key questions asked:

1. What is the historical background of the project?

2. What are the political aspects of the project?

3. What is the desired goal of the project?

4. Discuss the resourcing of the project.

5. What other sources of information exist on the project?

6. How can the project be improved?

7. How is the project progressing towards that goal?

I also discussed the project and the various surveillance programs with the contracting staff, the subcontractor's staff, and other mental health care

professionals in the Fayetteville area. The basic questions I asked were:

1. Provide a description of the demonstration and any background information on the project.
2. Compare this to other mental health care treatment programs.
3. Identify the project's strengths and areas that can be improved.

Other Sources of Data:

1. DMIS
2. RAPS
3. MEPRS
4. Health Services Command perspective
5. Local data: workload, financial, and FTE
6. Industry literature
7. Project documents
8. Other surveillance systems

**Ethical Statement**

Because the study is a historical review there is no need for a formal ethics statement or approval of the Human Use subcommittee. However, I will provide a copy of the paper to the contractor, subcontractor, project officer Health Services Command, and the WAMC project officer for their review and comments.

**Milestones**

4 Nov 91	Submit GMPP
29-30 Nov 91	Draft GMP Intro and Literature Review
17-30 Dec 91	Complete interviews
1-3 Jan 92	Complete research of Contractor
24 Jan 92	Complete research of Subcontractor
7 Feb 92	Compare Womack's procedures to Contractor's
3 Mar 92	Draft GMP review at ACHE
29 Jul 92	Preceptor reviews draft of GMP
9 Aug 92	Committee reviews draft GMP
17 Aug 92	Receive approval of my GMP

**Expected Findings and Utility of Results**

I expect to find the key elements necessary to execute a surveillance plan for a coordinated care contract involving a state agency and a civilian subcontractor. In addition, I expect to identify some of the important lessons learned which were brought to light by the surveillance program. These results could facilitate establishing a surveillance program for other health care contracts.

Secondary findings include how to improve the Fort Bragg Mental Health Demonstration project. In other words, what can be done to make the project more

efficient/effective. Also, the study should make it easier to implement a similar program.

### **III. RESULTS**

#### **Background Information**

The following information, compiled from the Defense Medical Information System (DMIS), indicates the need for managing mental health care in the Fort Bragg catchment area. In Fiscal Year 89, the Fort Bragg Medical Activity issued 629 non-availability statements (NAS) to patients in need of mental health services. Womack personnel authorized these NASs because Womack Medical Activity lacked the necessary resources to provide treatment to them. The number of NASs increased 52% since 1982. This CHAMPUS requirement is in addition to the significant amount of psychiatric care provided within Womack Army Medical Center (WAMC).

The following table reflects the overall situation facing WAMC. This table compares inpatient (child and adult) mental health care of Womack Army Hospital with the Womack catchment area's CHAMPUS mental health inpatient data from 1989.

	Admissions	Bed Days	Cost	Cost/admission
Womack	624	2,794	\$1,105K	\$1,600/adm

% of total	4%	4%	5%
CHAMPUS	629	15,785	\$6,166K \$9,800/adm
% of total	13%	46%	40%

(% of total refers to the percentage of mental health services as compared to the total. For example, 624 admissions for mental health patients is 4% of the total number of patients admitted to the hospital.)

Psychiatric care was the number one diagnosis accounting for CHAMPUS bed days. The fact that inpatient mental health care is six times more expensive through CHAMPUS makes it easy to understand why mental health care is a prime candidate for managed care. The following table shows the additional cost of mental health outpatient (Child and adult) care provided through the CHAMPUS program from 1989.

	Visits	Cost	Cost/Visit
Total Number	55,175	\$2,136K	\$38.70
% of total	6%	6%	

These figures highlight the magnitude of the mental health care costs facing Womack Army Medical Center.

All indicators point to significant increases in the demand for psychiatric services. Fort Bragg's rapid deployment mission causes additional stress on families stationed at Fort Bragg. This stress is expected to increase due to the increasing instability

in the "third world" and the corresponding increase in the likelihood of troops from Fort Bragg being deployed to meet these threats. Given these projections for significant increases in CHAMPUS mental health services, it is easy to understand the attraction to the promise of cost savings from adopting coordinated care.

All of the data demonstrate the need to initiate aggressive programs to gain control of escalating costs while maintaining access and quality of care. This need is the driving force behind the managed care initiatives at Fort Bragg.

As I have previously mentioned, one attempt to implement the concept of managed care at Fort Bragg is in the area of mental health care services for dependent children and adolescents of military families. Dr. Lenore Behar approached the Congress and the Department of Defense (DOD) with a plan to provide mental health services for CHAMPUS eligible children at reduced cost. The hypothesis the demonstration project is testing is: by providing a full continuum of care, including services not reimbursable by CHAMPUS, the cost per client can be reduced. The addition of alternative services, e.g. after school treatment, will provide less costly therapeutic options to inpatient

care. The projected cost savings range from 45% to 75% per client.

Dr. Behar is the Special Assistant for Child and Family Services, North Carolina Department of Human Resources Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Her plan calls for a 57 month demonstration project to evaluate how a more comprehensive continuum of care of mental health services would improve care and reduce the cost of treating the children of military beneficiaries. Once the Congress approved Dr. Behar's project, DOD gave the project to the Department of the Army. This means Health Services Command (HSC) has the mission for implementing this project. HSC contracts with the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse. The state of North Carolina subcontracts with a not-for-profit organization, created solely for executing this project. The demonstration project is organized into three main components: a) a headquarters element representing the N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse; b) Cardinal Mental Health Group, Inc., the subcontracted element which provides the patient care; and c) Vanderbilt University, which will evaluate the

demonstration project.

The headquarters has a project manager for Cardinal Mental Health Group, Inc. (CMHG). There is also a project manager for the Vanderbilt evaluation. In addition, the headquarters has a project accountant. The proposed annual budget for the state headquarters is \$292,601 (Project Budget Summary, Project Oversight Committee Meeting, July 92).

Cardinal Mental Health Group comprises roughly 200 employees. The vast majority of these employees are clinical specialists. Cardinal also subcontracts with other health care organizations for services, such as hospitalization and chemical dependency inpatient care. Additionally, Cardinal contracts with over a hundred health care providers for the majority of the outpatient treatment. In fact, approximately 80% of the patients are seen by contract providers (Project Oversight Committee meeting minutes, 1991). The major services provided by the Rumbaugh Mental Health Clinic are: inpatient care (subcontracted service), Residential Treatment Centers (RTC) (subcontracted Service), group homes, therapeutic homes, day treatment programs, emergency services, in-house services, outpatient treatment, and after care. The budget for (CMHG) is \$16,099,284 for FY 92 (Project Budget

Summary, Project Oversight Committee, July 92).

The contractor, the North Carolina's Division of Mental Health, Developmental Disabilities and Substance Abuse Services subcontracted with Vanderbilt University to conduct the evaluation of the demonstration project. The Vanderbilt evaluation consists of data analysis of the Fort Bragg area. In addition, the study is analyzing the Fort Campbell (Clarksville, TN) and Fort Stewart (Hinesville, GA) as the control sites. The study will analyze client progress, treatment outcome, and treatment costs.

The effectiveness of the patient care will be measured through a series of four interviews per patient. The evaluation team consists of approximately 34 personnel. The majority of the personnel are in the Nashville area. Most of the remaining personnel are found in the three data collection areas. The budget for the Vanderbilt evaluation is \$1,227,279 in FY92 (Project Budget Summary, Project Oversight Committee, July 92).

The cost study involves analysis of data tapes for control sites and cost data for FT. Bragg.

The Demonstration project is exploring four central questions:

1. Are there improvements in clinical outcomes as

measured by behavior change using standardized scales; by decrease in symptoms determined by clinical assessment; and by positive change in indicators of social and educational functioning and are there reductions in costs? If so, can these outcomes be attributed to the demonstration project?

2. Does the concept of continuum of care and case management impact upon the cost/effectiveness of the project? What factors and processes contribute to the outcomes? What are key ingredients that produce positive effects?

3. Is the quality of care provided equal to or better than the type of care provided at the control sites where services are delivered in a traditional manner?

4. What is the most efficient way to implement this program at other sites? What are the key features of this program that should be included in any replication?

The final essential element of background information is the extremely political nature of the project. It is critical to keep in mind how the program got its start. Dr. Behar approached Congress with a Demonstration Project designed to provide better child/adolescence mental health care at less cost than conventional CHAMPUS. Congress directed the Department

of Army, through the Department of the Defense, to execute the project. Since the Department of the Army did not ask for this project there was some hostility to the project right from the start. In general, the military, to include personnel at the Office of the Civilian Health and Medical Program for the Uniformed Services (OCHAMPUS), do not believe the project is cost effective and should be canceled. However, the contractor consistently presents to Congress a more convincing argument to continue the project than military's argument to cancel the project. As a result, Congress consistently authorizes more money for the project. This situation only frustrates the opponents of the project, and thus, increases the hostility between the two parties.

Obviously, there are no written sources describing the mistrust between the contractor and the military. Yet, the politics of the project are such a critical dimension of the project it cannot be overlooked. This polarization over the merits of the project is very unfortunate because the overall concept of providing cheaper/more effective forms of treatment deserves a fair test. What makes this situation even more regrettable is much of the problem lies in poor communication between the contractor and the military.

Rather than aggressively working together to achieve the goal of better services for a lower price, both sides spend a tremendous amount of resources defending their position. Regrettably, these efforts do nothing for the children in the Fort Bragg catchment area.

The two main items under contention between the contractor and the military are: the cost of the project (I will explore the cost issue in some depth later in the paper.) and the quality of care. I will highlight each of these issues when I describe the outcome of the surveillance plan. So, while the focus of my paper is on the surveillance aspect of the contract, the political aspects of the project cannot be ignored.

#### **Review of the Contract**

The heart of any contract is the description of the deliverables - what exactly is the contractor going to do? In a government contract the statement of work provides a summary of what the contractor is going to do. A clearly written statement of work is essential for a successful contract.

I included a copy of the SOW for the Rumbaugh Mental Health Demonstration Project. This is a copy of the Contracting Officer's Representative's (COR) SOW. The handwritten notes on the SOW are from the COR.

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These notes highlight some of the ambiguities with the contract. As you will see shortly, several of these ambiguities lead to problems with the overall execution/management of the contract. Therefore, it is important for contract oversight personnel to annotate the SOW for the contract they are managing with any ambiguities they identify with their contract.

A management indicator for senior managers is if the copy of the contract used by their contract oversight personnel looks like it has never been read there may be a problem with the oversight of the contract. A well written surveillance plan is based on a well written SOW.

The surveillance plan goes hand-in-hand with the contract. Unfortunately, in the case of the Rumbaugh Mental Health Demonstration Project, the surveillance plan was not ready for execution at the start of the contract. In fact, it was not until the summer of 1991, more than a year after the contractor began to treat patients, the surveillance plan was adopted and put into use.

To add to the lack of a detailed surveillance plan was the fact that the COR was the hospital adjutant, which is full time job. In a memo to the Commander of Womack Army Hospital the Chief of Staff for HSC

summarized the importance of the COR by saying, "The COR is an essential player at the ground level and needs to have the talent, time, and flexibility to [provide] oversight [to] the contract." (Connor, 1990, p.1). COL Connor goes on to suggest the COR be a full-time position. COL Connor's comments were in response to a request from Womack to HSC asking HSC to assume full responsibility for the contract given the contract was a Demonstration Project. To be successful, CORs needs to be able to spend 25-50% of their time performing surveillance. In the case of a new contract or an exceptionally complex contract, more than \$100 million, the COR probably needs to be working the contract on a full time basis.

An additional problem was the COR believed that since this is a cost contract, the COR did not need to certify contractor performance. The contractor also believed the COR had no surveillance responsibility. Couple these wrong impressions with the highly political nature of the project and a situation develops in which virtually all the military personnel involved with the project are attempting to keep the project at arms length. These factors did not support effective contract management.

Another problem during the first year of the

project was the COR was not a part of the information loop between the contractor, the subcontractor, and HSC. As a result, the COR was often unaware of important issues, and thus, unable to provide valuable information and assistance. To correct this shortfall personnel from HSC directed the contractor to make the COR the primary recipient of all communication. Unfortunately, it took until more than nine months before the contractor fully complied with this policy.

Another issue which took over a year to resolve was the question of whether the COR had the authority and responsibility to conduct surveillance of the subcontractors. This is an essential point because the actual patient care is provided by subcontractors and subsubcontractors. The subcontractors also account for 90% of the budget.

Additionally, there was a problem with how the COR conducted surveillance. In order for surveillance to be effective it must be random and spontaneous. If the contractor has time to prepare for the "inspection" the results of the surveillance can be easily anticipated. This unannounced aspect of the surveillance plan was difficult for the contractor to accept. This is especially true given the contractor was already conducting surveillance on the subcontractors, and

therefore, felt the COR's surveillance was an unnecessary waste of the subcontractor's time.

The lack of a surveillance plan accounts for many of the contract problems. HSC scheduled a planning conference in December of 1990. Yet, the plan was not ready to execute until the late summer of 1991. This exemplifies the confusion in the management of the contract. Much of this confusion stemmed from a lack of a clear mission statement that clearly defined responsibilities. Without a clear mission statement it was impossible for WAMC to expect HSC to take charge. The reverse was true, HSC believed, as they stated in several written correspondences: The COR function is best managed at the medical treatment facility (MTF) level. The contract was well into the second year before the MTF staff and HSC personnel developed into an effective contract management team.

#### **Highlights of the Surveillance Plan**

I included a copy of the COR administrative surveillance plan in Appendix D and Appendix E consists of examples of surveillance checklists. (PRIMUS [the Army's acronym for their primary care clinics] contracts are also a good source for information on developing contract management standards.) The

surveillance plan is self-explanatory. While the surveillance plan is easy to comprehend, the challenge for the COR is finding the time to review the necessary material to assess each area of the plan. It is also important to note the plan only deals with administrative elements of the contract. HSC assigned a child psychiatrist to manage the clinical review issues. Given the complexity of clinical review there is no surveillance checklist.

The one aspect of the contract which is still lacking a formal surveillance plan is the Vanderbilt evaluation team. No one from WAMC performs any detailed oversight for the project evaluation part of the contract. In addition, there appears to be little formal surveillance of Vanderbilt by anyone from HSC or WAMC. Although, personnel from HSC have analyzed the Vanderbilt work in sufficient detail to voice concerns about exactly what the evaluation is evaluating and how it is being studied. Given the Vanderbilt evaluation of the Demonstration Project costs several million dollars, there should probably be a formal surveillance plan for Vanderbilt.

Surveillance is a time consuming process. Therefore, any tool, such as a checklist, should be employed to maximize efficiency/effectiveness. This is

especially true if the COR plans to employ junior enlisted soldiers and/or civilian clerical personnel in the administrative reviews. The example checklists in Appendix E are self-explanatory. Appendixes E-1 through E-3 are COR checklists for the Rumbaugh Demonstration Project.

The contractor also has surveillance responsibility for the subcontractors. Appendixes E-4 through E-6 are the contractor's surveillance checklists. Note Appendixes E-4 and E-5 are clinical checklists used by the psychiatrist the contractor employs to conduct clinical review of the subcontractors.

As I will describe in the next section, the surveillance plan facilitated the COR identifying numerous contract deficiencies. However, this surveillance plan is not the "gold standard" for surveillance plans. I included the plan as a reference for anyone who might have a need for an example surveillance plan to use as a place to start in preparing their own surveillance plan.

#### **Outcome of the Surveillance Plan**

I will now highlight the results of the surveillance program by summarizing some of the

surveillance reports. The first surveillance operation, based on the COR's surveillance plan, took place during the last week of August 1991. The following are the main deficiencies noted. (As I mentioned earlier, surveillance identifies areas in which the contractor is not meeting contract specifications. Therefore, surveillance is a very negatively oriented activity. Taken by themselves, the results of the surveillance I will describe would indicate poor performance on the part of the contractor. Because the results of the surveillance program paint the project in a poor light, I included the interim report from the Demonstration Project Evaluation Team, Appendix B. In general, this report indicates the project is achieving its goals.)

There were two major problems identified in August. The first one was the majority of the providers were not properly privileged. The second problem was 10 patients diagnoses did not meet the criteria for care authorized under CHAMPUS.

Over the next several months the problem with the privileging continued without significant improvement. In fact, the entire Quality Assurance/Quality Improvement (QA/QI) program was not achieving the Joint Commission on Accreditation Healthcare Organizations

(JCAHO) standards. Additionally, the COR's summary for the period October-November 1991 identified the contractor/subcontractor were not meeting the terms of the contract regarding board certification of the psychiatric staff. The contract clearly requires a board certified or board eligible child psychiatrist to sit on each treatment team. The project does not have any board certified child psychiatrists and only the project medical director is board eligible. In fact, none of the staff is even board certified in adult psychiatry. Given the November report also shows the first indications that some patients are not receiving an accurate diagnosis, the implication of the lack of training of the psychiatric staff is obvious.

The November report confirms the trend that approximately 1% of the patients receiving care are ineligible. The COR also identified a problem with timeliness of care. Beginning with a failure to conduct the intake assessment in accordance with (IAW) the contract to case management issues not occurring in a timely fashion.

The November report is the turning point in the surveillance of the project. The November surveillance summary shows the surveillance plan is working and why it is necessary to conduct surveillance.

Unfortunately, the problems with the QA/QI should never have happened. These issues should have been reviewed before the first patient was seen. The problems in QA/QI highlight why surveillance should not begin after the contract has had a period to become fully operational. The sooner the COR identifies deficiencies, the sooner the contractor can correct them. That is the goal of surveillance: insure the contractor is accomplishing the mission to the given standard.

A team from HSC conducted a follow-up review on the deficiencies in the QA/QI program. The findings of that review indicated the project personnel had not corrected the problems in the QA/QI program. These problems were first identified by members of the HSC staff as early as the Spring of 1991. Some of the problems pre-date that Spring time period. As a result of the Fall 91 review, contracting personnel from HSC made the decision to issue a "cure notice". A cure notice is a warning to the contractor that serious problems exist with the contract and the contractor is given a deadline to correct the problems or face the termination of the contract.

In response to the cure notice the contractor brought in a QA/QI expert who was able to establish a

viable program. The re-inspection of the QA/QI program by personnel from HSC found the contractor had corrected the problem areas. Once again, these problems would never have occurred had an aggressive surveillance program been in place prior to the start of the contract.

Another item identified as a result of the surveillance program is the number of patients receiving inpatient/RTC treatment is roughly the same as pre-project figures. A major element of the Demonstration Project was the plan to use less expensive services to reduce the number of patients in the more expensive levels of care. The contractor claims the lack of a significant reduction in inpatient/RTC use is due to the fact the Fort Bragg catchment area was underserved. In other words, patients needing inpatient/RTC treatment were not getting it through the pre-demo health care system.

The contractor also points to the reduced percentage of patients receiving inpatient care. Unfortunately, the number of children receiving mental health services has more than doubled since the project began. So, the reduced percentage of patients receiving inpatient care is a function of simple mathematics. (For example, 5 patients out of 500 is 1%,

5 patients out of 1500 is .3333%. Yes, the percentage is lower but have we accomplished anything other than dramatically increasing the number of patients requiring outpatient services?) Regrettably, this means the number of children in the hospital remains the same, thus, the cost for inpatient care remains the same.

Another goal of the Demonstration Project was to show how a full continuum of services would help provide better care and reduce costs. Yet, surveillance indicates only 4% of the patients are receiving non-traditional CHAMPUS services and this percentage has dropped since the start of the project.

During the March timeframe the QA/QI issue surfaced again. Of the 38 standards of care the QA/QI program is monitoring, 18 were not met. Also, timeliness of care continues to be a problem. For example, it takes over 30 days from time of referral to scheduled intake/assessment (non-emergency patients). The standard is 21 days.

As is the case with any large project there are sensational items which are small in their cost but which call into question the management of the contract. Here are a few of the questionable areas of the budget for the Rumbaugh Demonstration Project:

1. Children in the Therapeutic Group Homes receive \$20 per month as an allowance.
2. The budget calls for more than \$34,364 to be spent on taxi cabs to transport patients.
3. The subcontractor spends more than \$99,750 on vehicles which generally do not meet the Government standard for allocating vehicle support.
4. The travel/training budget is roughly the same amount as it is for WAMC. Yet, WAMC has seven times the number of personnel and 50 times the physician staff.

#### **Cost Analysis**

While the quality of care is becoming a growing concern and should receive an increased amount of surveillance activity, the major problem with the contract is the magnitude of the cost overrun. The original budget for the Demonstration Project was \$5,773,466, of which almost 20% was earmarked for the Vanderbilt evaluation. The budget requirements identified at the July Project Oversight Committee meeting were \$17,619,164. This is more than a 300% increase in the cost of the project in just two years. Presently, the Demonstration Project is costing almost as much as all CHAMPUS costs combined in the Fort Bragg

catchment area. At this rate of growth, the project will cost more than \$40 million a year by the end of the contract. So, it is easy to understand why the focus of the surveillance efforts are on the cost of the contract.

While one would think cost is a clear cut issue, it is not. Remember what the contractor's cost goal was: reduced cost per patient. With this as a goal the contractor can be successful and yet the cost of child/adolescent mental health services can climb to more than five times what it was before the project began. In other words, increased volume (number of patients) will wipe any savings generated by a reduced cost per patient. The contractor's goal is significantly different than the military's goal of reducing overall expenditures. If I had to single out one reason the contract is not going to succeed it is this fact that the contractor's goal is not the same as the military's. As a result, cost is the main source of disagreement between the contractor and the military.

CHAMPUS costs for child/adolescent mental health services prior to the start of the Demonstration Project were \$3-4 million per year as compared to the \$16-17 million the demo is costing in FY 92. The cost

per beneficiary was \$89 before the demo, now it is almost \$362. Fort Bragg was ranked 27th out of 37 MTFs in expenditures for child/adolescent mental health care. Now Fort Bragg is the second most expensive MTF.

While some would argue comparing the Tidewater Mental Health Demonstration to the Rumbaugh Mental Health Demonstration may be comparing apples to oranges, I include the cost figures because I believe they do provide a valid source of comparison. In FY 91 the Tidewater budget was roughly \$30 million for a beneficiary population of 250,000. (Rumbaugh beneficiary population is approximately 45,000 children.) These figures produce a cost per beneficiary of \$120. Applying this figure to the Fort Bragg catchment area and the budget would be \$4.9 million, which is almost the exact figure for the original budget for the Rumbaugh Demo. So, critiques of the Rumbaugh Demonstration Project would argue that RMHDP is three times as expensive as the Tidewater Demo.

There are 1,600,000 dependent children of U.S. military personnel (Pehrson and Lee, 1991). So, if the cost per beneficiary from the Rumbaugh Demonstration were applied to the entire DOD

beneficiary population, the cost of mental health services for children would be approximately \$569.6 million. This figure would account for over 90% of the entire 1991 CHAMPUS mental health care expense.

Another major issue on cost is the difference between the cost of a patient being treated by the Rumbaugh Clinic staff versus being cared for by one of the providers with which Rumbaugh subcontracts. In FY 91, it cost \$8.3 million to operate the Rumbaugh Clinic. The clinic staff saw 197 patients. So, the cost for a patient to be seen by the Rumbaugh staff is \$42,131. During FY 91, 1,249 patients were sent to contract providers. The cost for contract providers was \$5.7 million. Thus, the cost per patient sent to a contract provider is \$4,563. The cost of contract providers includes the most expensive levels of care, inpatient and RTC. While this is an extremely crude cost comparison, it is still very hard to accept a ten fold difference between staff and contract care.

The results of the surveillance program clearly supports the military position that the demo should be managed by a new organization. In fact, the key players at HSC believe the demo should be converted into a managed care initiative, run by personnel from the Fort Bragg MTF.

#### IV. DISCUSSION

I tended to discuss the results of my research as I presented it. So, I will use the discussion section of the paper to highlight the lessons learned from the surveillance aspect of the contract.

The contract oversight team must have the specifics of their surveillance plan incorporated into the final draft of the contract. Moreover, the oversight team must begin executing their oversight, through the use of the surveillance plan, in the early stages of the contract. Good surveillance makes for good contractors just like good fences make for good neighbors.

A challenging area for any contractor is QA/QI. Given that many mental health professionals do not have extensive familiarity with QA, this needs to be an area that the oversight team closely monitors early in the contract. In fact, the oversight team should begin to review the QI plans before the first patient is seen. (This was not only a problem with the RMHDP but with the Tidewater Project as well (Burns et al., 1989))

While it is apparently politically unthinkable, a very effective means of cost control is by increasing the patients out-of-pocket expense. This can be increased co-pays, deductibles, a nuisance fee or a

combination of these techniques.

When there are multiple headquarters/agencies responsible for managing a contract there needs to be a detailed, written plan to integrate the surveillance needs for all levels of the contract management team. Some of the critical elements of this plan are: clear definition of responsibilities, specific formats for exchanging information and revising strategy for managing the contract, and method to coordinate surveillance with the contractor.

Avoid using military personnel as Contracting Officer Representatives. The Army standard of on-the-job-training is not the ideal method for learning contract management. While there are courses available to help familiarize people with contract management, I do not feel they fully prepare people to assume the principle oversight duties for a major contract. In addition, it takes time to become well versed in all the critical intricacies of a contract. The average life-expectancy for a military COR is 12-18 months. (The project is on its third COR, the current COR is a civilian whose sole mission is to perform duties of the COR for all WAMC contracts.) Twelve months does not allow the COR enough time to obtain enough knowledge of the contract and contractor to effectively administer

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the contract. Additionally, there is usually little to no overlap in positions when military personnel rotate. This means the contract is not being properly maintained for several weeks to several months, as the new COR learns the "ropes". Another method for insuring surveillance does not suffer during a change in CORs is to insure the Alternate Contracting Officer Representative is fully capable of managing the contract.

Insure penalties are written into the contract for failure to meet the established performance criteria. Wherever possible, it is also desirable to develop positive incentives to recognize excellence in meeting the performance criteria.

Never enter into a cost reimbursement contract. Basically, a cost reimbursement contract is a blank check for the contractor. Ideally, a capitated contract is the contract of choice.

Make the contractor part of the team that develops the surveillance plan. This will avoid misunderstandings and mistrust on the part of the contractor.

## V. CONCLUSIONS AND RECOMMENDATIONS

The main recommendation I would commend to the reader is to watch for the potential pitfalls described in this paper and to pay close attention to the lessons learned on managing a mental health managed care contract.

The intent of my research was to show how critical the surveillance plan is in contract management. In the case of the Rumbaugh Demonstration Project, proper surveillance identified serious quality of care and cost issues. Presently, there are three major areas in which the contractor is not in compliance with the contract.

1. The Rumbaugh staff does not have enough board certified or board eligible child psychiatrists. (It is really questionable research methodology conducting a test in providing better mental health care to children when there are no child psychiatrists on the project staff.)
2. The QA/QI program continues to have difficulties meeting JCAHO (contract) standards.
3. The timeliness of treatment is still not meeting contract specifications.

Clearly, the COR surveillance plan is working and will continue to facilitate the COR accomplish his mission

of monitoring contractor performance.

The success of the surveillance plan for the Rumbaugh Mental Health Demonstration Project should highlight the importance of aggressive contract oversight. Effective contract management is essential if managed care is to successfully address the nation's health care crisis. As exemplified by the Rumbaugh Mental Health Demonstration Project, mental health services are a prime candidate for managed care or coordinated care, as the military prefers to refer to the concept of managed care. Obviously, other health care services are likely areas to apply the principles of managed care.

Never forget that managed care, reduced to its simplest component, is nothing more than a contract. As long as there are dedicated people, using a well thought out surveillance plan to oversee the contractor the system will work.

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## **APPENDIX A**

### **DEFINITIONS**

## **DEFINITIONS**

**CMHG - Cardinal Mental Health Group, Inc.**

**CHAMPUS - Civilian Health and Medical Program of the  
Uniformed Services**

**COR - Contracting Officer's Representative**

**CRI - CHAMPUS Reform Initiative**

**DOD - Department of Defense**

**FHC - First Hospital Corporation**

**FY - Fiscal Year**

**HSC - Health Services Command**

**IAW - In Accordance With**

**LOS - Length of Stay**

**MTF - Medical Treatment Facility**

**NAS - Non-availability Statement**

**OCHAMPUS - Office of the Civilian Health and Medical  
Program for the Uniformed Services**

**POC - Project Oversight Committee**

**RMHDP - Rumbaugh Mental Health Demonstration Project**

**SOW - Statement of work**

**WAMC - Womack Army Medical Center**

**APPENDIX B**

**INTERIM REPORT ON THE PROJECT**

**THE FORT BRAGG EVALUATION PROJECT:**  
**THE INTERIM REPORT**

**April 28, 1992**

**Center for Mental Health Policy**  
**Leonard B. Bickman, Ph.D., Director**  
**Vanderbilt Institute for Public Policy Studies**

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## **CHAPTER 1**

### **INTRODUCTION TO THE INTERIM REPORT FOR THE FORT BRAGG EVALUATION PROJECT**

#### **Purpose of the Report**

This is an interim report of the Fort Bragg Evaluation Project that is required under the contract with the State of North Carolina, due 30 months after the start of the Evaluation Project. It is intended to provide a picture of the Evaluation Project's findings to date. It should be stressed, however, that the findings in this report should not be considered conclusive, since only partial data are reported here and each sub-study of the evaluation is currently in progress. These studies should be completed for the final report that is due at the end of the project.

#### **The Problem that the Demonstration Addresses**

Strong consensus exists concerning the problematic manner in which mental health services are provided to children. Many children do not receive any services and others receive inappropriate services. In the past two decades, experts (Knitzer, 1982; Stroul & Friedman, 1986) have highlighted the vast discrepancy between the numbers of children and youth in need of mental health services and those who receive appropriate services. It is estimated that 11-19% of children and adolescents are in need of mental health services (Saxe, Cross & Silverman, 1988; Tuma, 1989). More than half of these children receive no treatment, and many who are treated are receiving inappropriate care (Saxe, Cross, & Silverman, 1988). Senator Inouye (1988) maintains that 80% of the children who need services are receiving inappropriate care or none at all.

There is also agreement that unnecessarily restrictive treatment settings are over-utilized (Dorwart, *et al.*, 1991; NMHA, 1989; Weithorn, 1988). Children with emotional problems are best treated in the least restrictive, most normative environment that is clinically appropriate. However, according to Congressional testimony, the number of children placed in private inpatient psychiatric settings increased from 10,764 such placements in 1980 to 48,375 in 1984 -- a 450% increase (Stroul & Friedman, 1986). Moreover, the number of private psychiatric hospitals continues to grow (Bickman & Dokecki, 1989). The best estimate (Burns, 1990) to date is that more than 70% of the funding for children's mental health services nationwide is spent on institutional care.

Contributing to this problem is the fact that alternative treatment settings are generally unavailable. Knitzer (1982), Behar (1985), and Silver (1984) all reported that approximately 40% of inpatient placements were inappropriate because either the children could have been treated in less restrictive settings, or the placements that were initially appropriate were no longer appropriate, but less restrictive treatment settings were not available. This remains the situation in spite of evidence that even severely emotionally disturbed children can receive treatment while living in their own homes when a comprehensive system of care is present in the community (Behar, 1985; Moran, 1991).

Even where services are available, the lack of coordination between programs compromises the effectiveness of the interventions (Saxe, Cross, Silverman, Batchelor, & Dougherty, 1987; Soler & Shaffer, 1990; Stroul & Friedman, 1986). Given the developmental complexity and multiple needs of children and adolescents, services must be both available and coordinated (Behar, 1985). In addition, evidence indicates that a dedicated program of research is necessary to close gaps in the data base regarding service system issues and to build the knowledge base pertaining to children's mental health service systems (Burns & Friedman, 1990).

### **Continuum of Care as an Alternative to Traditional Systems**

The continuum of care approach has emerged in response to the problems characterizing mental health service delivery systems for children and adolescents. The term *continuum of care* refers to the comprehensive range of services required to treat severely disturbed children and adolescents that includes both nonresidential and residential services (Stroul & Friedman, 1986). As children's mental health services are moved toward a managed care system, an emphasis on mid-range or intermediate level services is also emerging (Broskowski, 1992; Rodriguez, 1992). This approach attempts to deliver needed services on an individualized basis and in a coordinated manner, relying on case management to integrate treatment programs and facilitate transitions between services. It also is designed to be community-based, involving various agencies pertinent to children's developmental, social, medical, and mental health needs.

There has not been a definitive study that has demonstrated the superiority of the continuum of care model to the traditional method of service delivery. There is controversy about managed care systems in general and its application to children's mental health services by CHAMPUS has recently been a subject of a congressional hearing (Nelson, 1992). The Fort Bragg Evaluation is the first comprehensive evaluation of a system of care that includes the assessment of mental health outcomes.

### **The Fort Bragg Demonstration Project**

The high cost of providing mental health services to the children and adolescents of military personnel stimulated the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to consider alternatives to the existing delivery system. In 1983, CHAMPUS alone spent \$74 million on inpatient mental health hospitalization for dependent children. Between 1985 and 1989 mental health costs for both children and adults doubled to more than \$600 million per year even though the number of beneficiaries remained relatively constant. Inpatient care increase from \$200 million to almost \$500 million in the same 5 year period and mental health care to children and adolescents in hospitals and residential treatment centers accounted for 3 out of every 4 days of inpatient mental health care (GAO, 1991). Recently, the DOD has responded to the increases in CHAMPUS costs by implementing a Coordinated Care effort that makes local hospital commanders responsible for limiting expenditures in their catchment area. Under Coordinated Care, more beneficiaries are treated in military hospitals. The Department of Defense has also authorized payment of partial hospitalization beginning May 1992.

In pursuit of alternatives to traditional CHAMPUS services, the Department of the Army, in August of 1989, funded the Fort Bragg Child and Adolescent Mental Health Demonstration Project (the Demonstration) through a contract with the North Carolina Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS).

The State has contracted through the Lee-Harrett MH/DD/SA area Program with Cardinal Mental Health Group, Inc. (Cardinal), a private, not-for-profit corporation, to provide a continuum of care for the Fort Bragg catchment area. For a period of four years, mental health and substance abuse services are being provided to those in need to over 42,000 children and adolescent dependents of military personnel in the Fort Bragg area. Using a closed system or exclusive provider organization (EPO) model, families seeking services for their children and adolescents are required to use the Demonstration's clinical services, which are free, or they may choose to seek and pay for services on their own. The range of services includes both nonresidential and residential components. Cardinal has contracted with individuals and agencies in the community already providing traditional mental health services such as outpatient therapy and acute inpatient hospitalization and is itself a major provider of outpatient treatment. For the middle or intermediate level of the continuum, those services not previously available in Fayetteville nor typically available across the country, Cardinal developed services that include in-home counseling, after-school educational treatment services, day-treatment services, therapeutic homes, specialized group homes, 24-hour crisis management team, and outpatient treatment. All children and adolescents requesting services receive a comprehensive intake assessment to determine the appropriate level of service. These services are provided through the Rumbaugh Clinic.

For children using more than just outpatient services, the clinical services are coordinated with the other child-serving agencies/practitioners in the community, especially pediatric, education and protective services. Services within the continuum and across other agencies are linked together through a case management component. Related services to parents are also provided.

### **The Fort Bragg Evaluation Component**

The Center for Mental Health Policy of the Vanderbilt Institute for Public Policy Studies at Vanderbilt University, was awarded a subcontract by the North Carolina MH/DD/SAS to conduct an independent evaluation of the Demonstration. Four critical issues are addressed by the Evaluation Project:

1. implementation of the Demonstration and issues concerning its replication at other sites;
2. quality of two key service components provided by the Demonstration;
3. mental health outcomes of the children and adolescents who receive services at the Demonstration and Comparison sites; and
4. cost and utilization of services delivered at the Demonstration and Comparison sites.

These substudies tap the central issues in determining the merit of the demonstration and are thus critical areas that a comprehensive evaluation needs to consider. The Evaluation must first determine how the program was actually implemented so that the key features of the system can be described. It is also important to assess the quality of the system's critical components that play a major role in determining the success of the intervention. The Evaluation must also inform us about the success of the Project in changing children's lives. Finally the Evaluation requires an estimate of the cost of the services delivered so as to make the ultimate judgement about the cost effectiveness of the demonstration. The purposes and procedures followed in each of these substudies is described below.

## **Implementation Evaluation**

Essential to the conduct of a high quality evaluation is the need to address questions of program conceptualization, design, and implementation (Hargreaves & Shumway, 1989; Rossi & Freeman, 1985). This aspect of the evaluation examines the theories and assumptions underlying the hypothesis that a specific intervention should be successful, works toward ensuring that the program's major goals, individual components, and specific activities do indeed "fit together," follow a logical sequence, and appear likely to produce the desired outcomes. Moreover, as evaluators have been frequently reminded (e.g., Reznovic, 1984; Scheirer, 1981), it is unwise to simply assume that the program will be delivered as planned to its intended recipients. Various problems can surface, despite the best efforts of program architects, including: temporary or permanent obstacles to the program reaching all members of the target population; inability to provide the required treatment "dosage"; and consistent delivery of high quality treatment to all participants. Thus, it becomes important that structural, environmental, and/or political barriers responsible for diluting full-scale implementation of the program be documented.

Another reason for measuring program implementation is to gain better insight into the relationships between program inputs and outcomes. For example, determinations can be made as to which program elements or processes appear more effective than others and which classes of program recipients benefit most from the intervention. In addition, the thorough description of services actually provided will advance the field in the effort to define various components of the continuum of care. Finally, implementation data gathered throughout the course of the program (i.e., from its initial "start up" phase through its "fully operational" stage), can be used as a guide to others who wish to replicate the program in different sites.

The overall strategy for examining program implementation is based on both Chen and Rossi's (1983) "theory-driven" approach to program evaluation and Bickman's program theory (1987; 1990) and component theory (1985) of evaluation. Whereas the "theory-driven" perspective essentially aims at developing models that identify the causal and operational linkages among program elements, the component approach proceeds one step further. Here the emphasis is placed on discerning distinct philosophies, "subtheories," and activities, along with the linkages among these, within the individual program elements/components (see Graham & Birchmore-Timney, 1989 for an example of this strategy). Thus, combining these approaches should result in a descriptive model of program structure, process, and outcomes for the Fort Bragg service delivery system as a whole and for each of the service components that are incorporated under its administrative umbrella.

For the purposes of understanding and evaluating the program at Fort Bragg, this strategy seems particularly appropriate. The Demonstration is an attempt to develop and implement a model service delivery system for addressing the mental health needs of children and adolescents. At the same time, this system is composed of several different types of treatment settings and facilities. While all of these individual aspects of the program may subscribe to the overall philosophy and values held by Demonstration program administrators and staff, they also have their own set of theories and values that define and guide the structure, recipients, process, and outcomes of their efforts; not all of these may overlap perfectly with those of the Demonstration program. For example, one key element of the philosophy encompassed by the Demonstration Project concerns the need to involve the family in treatment. While this thrust has certain overarching features, the way it is operationalized on a daily basis by different components (e.g., the types and amount of information on the child's progress reported to the family by staff in residential treatment centers vs. group homes), or even by different providers within these components, may vary. As such, understanding both the set of theories and values that underlie the overall Demonstration service delivery system and those influencing the operation of its individual "building blocks" is important to assessing program implementation.

Once accurate conceptual and operational models of the program have been developed, they are translated into variables that can reflect the degree of program implementation. Here, the goal is to collect information that will assess coverage, bias, and outputs. Data for ascertaining the fidelity of the program to its intended conceptualization and design are obtained from six basic sources: (1) program services records on client characteristics, diagnoses, client movement through the Demonstration, and services delivered; (2) client files (e.g., types of case management received); (3) reports by parents and significant others (e.g., perceptions as to the extent they were involved in treatment); (4) reports by service providers and others involved in the child's treatment regarding the characteristics of services delivered; (5) peer review of treatment received (e.g., the extent to which the child was treated in the least restrictive, appropriate setting); and (6) observational data.

### **Determining the Quality of Services**

A significant issue concerning mental health systems in the coming decade is the need for research on assessment, monitoring, and improvement of the quality of mental health services (Bickman & Peterson, 1990; Peterson & Bickman, in press; Wells, 1988). Providers currently must meet the typically minimal requirements of legislative mandates, hospital accreditation programs, and private insurance carriers for providing quality care. However, the changing nature of the mental health system has stimulated the need for systematic research on the nature of quality. The body of research concerned with defining, assessing, and assuring quality of mental health services is not well-developed and, in fact, lags far behind advances in the physical health area, and in general, other mental health research issues. While there exists considerable philosophical and methodological difficulties in defining and measuring the quality of mental health services, the importance of this topic warrants vigorous investigation (Palmer, Donabedian, & Povar, 1991).

The quality assessment approach of the Evaluation has two tracks. One track reviews the quality improvement (QI) activities of Cardinal at the Demonstration site, which, according to the stipulations of the Department of the Army contract, follow the requirements of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Consistent with the JCAHO model, QI is a complex management tool, including (1) credentialing and privileging of clinicians; (2) monitoring against indicators of quality programming; (3) clinical care studies; and (4) utilization review. Indicators are developed for each service component to reflect issues of quality and to identify areas needing further investigation through clinical care studies. Examples of such indicators are (a) in emergency services, the number of clients moving from telephone interview to face-to-face interview to hospital admission per month; or (b) in diagnostic services, the number of days elapsing between the family's request for services and the scheduled intake assessment. Essentially, in areas where the Demonstration plans to implement QI activities, the Evaluation is assessing the extent to which the Demonstration meets its own QI criteria and standards.

The Quality Study is assessing, at the program level, the quality of two operational service components that are unique and crucial to the continuum of care model. These are components that are not direct treatment services (e.g., outpatient care, day treatment). Instead, the component level of evaluation focuses on two key aspects of the continuum of care -- intake assessment and case management. These two system components were chosen for analysis because they are especially vital to the effectiveness of the Demonstration model. Thus, they are defined, developed, and implemented differently in the continuum of care than in typical treatment settings.

This study utilizes a five-step process to develop the instrumentation to assess the quality of the intake assessment and case management components. The definition and measurement of quality is a value-laden activity that needs to take into account several factors: standards within the field, including external standards such as those of JCAHO, as well as those commonly accepted as "good practice" by professionals in the field. In addition, following from the health care field, increasing emphasis is being placed upon including the perspectives of consumers of services in defining quality. Because of the importance of obtaining these different perspectives in defining quality, a methodology called structured concept mapping (Trochim, 1989) has been used to obtain the perceptions of quality characteristics in the two components from key stakeholder groups at the Demonstration Project--administrators, the clinical staff in the two components, and parents whose children are receiving services.

The five activities that are being undertaken are these: (1) stakeholders' *conceptualization* of the characteristics of quality in the two components; (2) *development of the instruments* by combining information from stakeholders, existing standards (e.g., JCAHO standards) and prior research; (3) *review* of instruments by experts in the field and selected stakeholder representatives; (4) *pilot testing* and revisions; and (5) *validation* of instruments by comparing the ratings of an external evaluation team with self-ratings by staff in the components.

## **Measuring Mental Health Outcomes**

Currently, little information is available on the effects of innovative models of mental health treatment on clinical outcomes. Several major efforts are underway to demonstrate and evaluate systems of care, including the Robert Wood Johnson's Mental Health Services Program for Youth (Beachler, 1990) and the Ventura Project (Jordan & Hernandez, 1990). Attempts to individualize services are also being reported, such as Kaleidoscope in Illinois, the Alaska Youth Initiative, and Project Wraparound in Vermont (Burchard & Clarke, 1990). These latter efforts, however, have been aimed at small populations of children and adolescents with severely maladjusted behavior who were receiving intensive and expensive services, often out of state. Results released to date have focused on costs and levels of service, with little information on mental health outcome for the clients in question. Furthermore, this work is difficult to generalize to a community-based effort involving children and adolescents with a wide range of types and severity of problems.

Key questions that address mental health outcomes in the Fort Bragg Evaluation include:

- (1) Are there improvements in mental health outcomes of the children and adolescents served in the Demonstration?
- (2) Do the children and adolescents served in the Demonstration exhibit equal or greater improvement than comparable children and adolescents receiving mental health services in the Comparison sites?
- (3) What mediating factors and processes contribute to the outcomes?

Mental health outcomes are being studied longitudinally to assess whether children's clinical conditions improve more and faster than children in the Comparison settings. Additionally, the Evaluation is studying whether the children and their families are more satisfied with continuum of care services than comparable families at the Comparison sites. Follow-up interviews by Evaluation staff are taking place 6, and 12 months after the first interview.

Since the Evaluation is unable to utilize random assignment of children to different systems of care (Bickman, 1992), the inclusion of Comparison Sites in this project is critical in order to examine the effectiveness of the Demonstration. Two Comparison sites designated by the Army are located at Fort Campbell, Kentucky, and at Fort Stewart, Georgia, where children and adolescents receive care traditionally covered by CHAMPUS. These CHAMPUS covered services include psychiatric hospitalization, care in a residential treatment facility, and outpatient services. Moreover, there is no single point of entry nor coordination of services through case management as in the Demonstration. The sites involved in the study are the catchment areas serviced by the military hospitals of three southeast United States Army posts. The Demonstration site is the catchment area of Womack Army Community Hospital located at Fort Bragg, North Carolina. The Comparison sites are the catchment areas of Blanchfield Army Community Hospital, located at Fort Campbell, Kentucky, and Winn Army Community Hospital, located at Fort Stewart, Georgia.

In selecting the Comparison sites, primary consideration was given to the following factors: geographic location, size of military and dependent populations, types of units assigned and readiness requirements of the major command, and availability of on-post mental health services. Comparison sites were chosen based on their high degree of comparability.

The two Comparison sites selected are located in southeastern states that have climatic, geographic, and cultural conditions similar to that of North Carolina. Furthermore, as with Fort Bragg, each site encompasses multiple small to medium size civilian communities and is within 60 miles of a large metropolitan area. FY90 figures for the relevant dependent population of Fort Bragg, Fort Campbell, and Fort Stewart reveals that the Fort Bragg area is approximately equal in size and composition to the combination of the Comparison sites. Although the sites have different major commands and different non-divisional units, a number of similarities in mission exist that make the Comparison sites fairly similar to the Demonstration site.

It should be noted that in the winter of 1991 and spring of 1992 the types of services at these Comparison sites were altered under the Army's new Gateway to Care system. However, no data or information about the clients or this new system is provided in this report. The final report will discuss the introduction of the Gateway system.

### **Data collection strategies**

The primary sources of mental health outcome data are the research participants themselves -- the children and adolescents and their families who are receiving mental health services at the Demonstration or the Comparison sites. These interviews use multiple measures and are designed to be: (a) comprehensive, providing information on a multitude of child and family variables; (b) standardized, through the use of established instruments and trained interviewers; and (c) feasible, asking children and parents to provide adequate but not excessive amounts of information.

The Evaluation emphasizes the recruitment of study participants who are receiving *more* than outpatient care (e.g., day treatment, residential treatment, family preservation, inpatient). The importance of focusing on these clients is primarily motivated by two factors. First is the significance of this population. This is the most costly group to treat, as well as most severely ill group in treatment and in the population. Second, it is of great theoretical significance to have a sample of sufficient size with which to compare the wide range of services and outcomes from the Demonstration site with the limited range of services and resulting child and family outcomes from the Comparison sites. Thus, the Evaluation rather than attempting to recruit a representative sample of clients at either the Demonstration or the Comparison sites has focused on the more severely disabled at all sites.

After a child or adolescent is recommended for treatment by the intake assessment team at the Demonstration site or enters services at the Comparison sites, the Evaluation staff conducts the first of three comprehensive, in-person interviews with the child or adolescent and family. The primary data collection effort focuses on the children's clinical functioning. The data on children includes psychiatric status, behavior problems and social competence, level of functioning, self-esteem, and school adjustment and achievement. Data are collected through similar interviews with the child and parent, as well as through self-report measures and questionnaires.

The instrument package developed for this study consists of a combination of structured and semi-structured interviews, behavioral checklists, and self-report questionnaires. Most of the instruments have been well standardized and have been used in similar research on child psychopathology. The domain of child psychopathology is measured by the Child Assessment Schedule (CAS) (Hodges, Kline, Fitch, McKnew, & Cytryn, 1981; Hodges, Kline, Stern, Cytryn, & McKnew, 1982), including the parallel form, the Parent-CAS (PCAS); selected modules from the revised Diagnostic Interview Schedule for Children (DISC-2.1) (Shaffer, Fischer, Piacentini, Schwab-Stone, & Wicks, 1989); the Child Behavioral Checklist (CBCL) (Achenbach & Edelbrock, 1983); and the Youth Self-Report (YSR) (Achenbach & Edelbrock, 1987) for teenagers. The Family Background Form (FBF) and the Interview Protocol for Family Makeup and Child's Treatment Background, both developed at Vanderbilt, are used to collect background information, including the child's physical and mental health history, experiences with schools, and contacts with law enforcement and court systems.

To measure social functioning, a questionnaire, the Self-Perception Profile (SPP) (Harter, 1982), is used. The CBCL and the YSR also include items that measure social functioning. In addition, the interviewer completes the Global Level of Functioning (GLOF), a modification of the Child Global Assessment Scale (CGAS) (Shaffer *et al.*, 1983), and the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges & Ring-Kurtz, 1991), developed by Kay Hodges in conjunction with this project and modeled after the North Carolina Functional Assessment Scale (NCFAS), which was developed primarily for use with adults.

An additional questionnaire was developed by Vanderbilt to measure how satisfied clients and their families are with the services they receive at the Demonstration and Comparison sites. Issues addressed at both the individual service component and global levels include: (a) access and convenience; (b) involvement in treatment decision-making; (c) relationships with therapists and other staff members; and (d) expectations and effectiveness of services. Additional collateral data were collected from the child's teacher using the Teacher Report Form (Edelbrock & Achenbach, 1984) and from the child's therapist using a survey specially developed for this project.

In the development of this package, each instrument has undergone a series of pilot-tests and refinements based on feedback received. Several of the instruments have been adapted for use in this package and altered to eliminate duplication of items among instruments and to enhance readability. The instrumentation package has undergone review by members of a family advocacy organization as well as black and hispanic mental health experts for possible cultural biases.

### **Data management/quality assurance**

To assure high quality interview data, all interviewers participate in an intensive 5-day training program and subsequent independent work. To qualify to collect data, each interviewer must reach criteria ( $Kappa = .90$ ) in the administration of the Child Assessment Schedule (CAS) to five practice cases. In order to maintain quality, every interview (with the subject's permission) is recorded on audiotape. A 10% sample of each interviewer's tapes is reviewed by a trained instructor.

## **Cost and Utilization Analysis**

The primary objective of the Cost study of the Evaluation Project is to determine whether the cost of delivering continuum of care services is comparable or lower than the cost of delivering care at the Comparison sites.

Many interested parties including mental health professionals, managers of managed care programs and insurers require information on mental health care delivery systems that promise reduced use of expensive and restrictive inpatient care and smoother transitions from critical episodes back to fully normal lifestyles. To serve this broader interest, a different definition of relevant costs is necessary. All the costs borne by any segment of society are potentially relevant, though some of these costs may prove, on close inspection, not to involve the use of scarce resources but merely to transfer titles of resources among individuals, corporations, and government units.

Cost data is being assembled from both the Demonstration site and the Comparison sites. Efforts are being made to express all costs in dollar terms, either through measurement or estimation. However, as noted by Weisbrod (1981), there likely will be some costs that are very difficult to express in dollar terms (e.g., psychic losses). The magnitude of these will be estimated and compared across study sites without conversion to dollar units.

At the Demonstration site and the Comparison sites, the research team is collecting cost data at the system level as well as on individuals participating in the study. The system level data allows estimation of total and average resource consumption for client sub-populations while the individual-level data permits estimation of costs associated with different treatment regimes. In addition, the individual cost data serves as a check on system data. For example, if the system level data suggest a reduction in costs for children with behavioral disorders, the research team will look to the sample of such children (using the diagnoses determined by the research team) to determine whether the apparent reduction in costs is actual or is due to changes in diagnostic procedures by mental health providers.

The general strategy for assessing the cost of each service includes three steps: (1) development of a list of resources consumed, including units of each resource; (2) estimation of a unit dollar value for each resource; and (3) estimation of total dollar costs by multiplying resources consumed by appropriate unit dollar values and summing these products. Developing the list of resources and estimating unit costs often relies on the same data source. For example, billing records provide lists of resources consumed as well as initial estimates of the dollar value of those resources. However, in many cases alternative data sources (i.e., sources other than those used to estimate resource consumption) may be used as estimates of unit costs. For example, with some resources, national estimates of unit cost may be used in place of local figures.

The ultimate objective of the costs and utilization component of the Evaluation is to estimate the cost-effectiveness of the Demonstration and to compare that estimate to the cost effectiveness of alternatives. This interim report is a preliminary examination of the Department of the Army's costs for clinical services at the Demonstration at Fort Bragg. It compares total Department of the Army costs and service utilization at Fort Bragg to CHAMPUS costs and utilization at the Comparison sites. As a further comparison, data from CHAMPUS's Regional Workload Summary for Fort Hood are used to examine per capita costs and utilization.

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## **CHAPTER 2**

### **THE IMPLEMENTATION STUDY**

The general purpose of the Implementation Study is to ascertain to what extent the Demonstration was implemented as planned and which aspects of the program should be included in any replication efforts in the future. The initial efforts of the Implementation Study have been focused on the documentation of the actual implementation of the Fort Bragg Child/ Adolescent Mental Health Demonstration Project and any discrepancies from the original plan. These efforts also have involved examination of the major activities undertaken to plan and develop the continuum of care and, thereafter, to begin delivering services to the children and adolescents in the Fort Bragg area and the factors that either facilitated or erected obstacles to successful implementation. The following chapter is divided into two sections that report on two discrete stages of implementation of the Demonstration:

- ◆ August 18, 1989 - May 31, 1990: the time period between the award of the contract and the initiation of service delivery during which the continuum of care was to be planned and developed.
- ◆ June 1, 1990 - June 30, 1991: the first thirteen months of service delivery.

Each section contains information on the methods used in the Implementation Study in addition to the results of the study.

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Between August 18, 1989, and May 31, 1990, the contract for the Fort Bragg Child/ Adolescent Mental Health Demonstration Project was awarded and the service delivery system was developed. During this "start-up" period, in general, it can be concluded that several of the major tasks required for getting the Fort Bragg Demonstration Project "up and running" were accomplished by the two units responsible for developing the program -- i.e., the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) located within the North Carolina Department of Human Resources and Cardinal Mental Health Group, Inc., through the Rumbaugh Child and Adolescent Mental Health Clinic. As the actual contract awardee, MH/DD/SAS carried out the key managerial activities that culminated in the formal dedication of the Major General James H. Rumbaugh, Jr., Child and Adolescent Mental Health Clinic on May 14, 1990 and its official commencement of providing services to clients on June 1, 1990. Included in these efforts were such prerequisite tasks as acquiring the facility, arranging for a nonprofit corporation to serve as the formal administrative and legal entity for the Demonstration's operations, negotiating funding agreements, establishing mechanisms for monitoring and oversight, and hiring key administrative staff for services planning and management. The Division of MH/DD/SAS also was responsible for arranging that an independent, comprehensive evaluation of the Demonstration was set into motion.

Examining Rumbaugh Mental Health Clinic itself, the majority of "start-up" tasks centered on the creation of the two major organizational segments necessary to implement the continuum of care (i.e., the configuration of clinical services and the administrative structure to support these services). In terms of developing the necessary management structures and support services, significant effort was devoted during the early months of the project to: hiring staff who would administer components of the continuum of care and/or who would deliver services; developing the necessary procedures for accounting, billing, and payment; formulating the numerous policies and procedures required for functioning as a mental health organization; and dealing with various constituencies and community groups (e.g., future referral sources, other local mental health professionals, and the families of CHAMPUS beneficiaries). For the most part, these efforts were successfully completed. Delays did occur, however, in terms of finalizing contracts with local providers, having a functional utilization review system, and having a fully operational management information system by June 1, 1990.

The major components encompassed by the continuum of care -- i.e., a centralized intake assessment system, the array of treatment services, and case management -- also differed as to the "progress" made toward full-scale implementation. As of June 1, 1990, although the intake assessment and outpatient services components were operational, this was not true for each specific treatment option within the continuum (i.e., residential services and community education and treatment). This delay in developing alternative "step-down", residential services was, however, in accordance with the Army's instructions set forth during contract negotiations, based on its expectation about the level of demand for these interventions.

The second time period, June 1, 1990 - June 30, 1991, involved the first thirteen months of service delivery, during which the major activities were directed at acquiring resources, distributing them throughout the organization and service system, and developing monitoring and accounting procedures for tracking how these resources were allocated and expended. An intense amount of effort continued to be directed to acquiring needed resources. This effort was a result of an immediate surge of request for services that far exceeded planning estimates. Directly related to this issue were increase in the client load, increase in the budget, increase in the staffing plans, and contracting with private providers. As new resources were added to those already in place, decisions regarding how they would be allocated to the various administrative and clinical components of the Demonstration were continually made. This involved not only receiving and distributing funds but also prioritizing client care and coordinating services and resources.

The actual clinical services provided in the continuum of care by June, 1991, comprised several components: (a) intake assessment and emergency services; (b) case management; and (c) treatment provided by Rumbaugh and contract providers, including: outpatient, day treatment and afterschool programs, in-home therapy and crisis intervention, residential, inpatient, psychiatric and substance abuse services.

Factors that either facilitated the implementation of the Fort Bragg Child/ Adolescent Mental Health Demonstration Project's efforts or erected obstacles to successful implementation are discussed in Chapter 2.

**Section 1**  
**Developing a Continuum of Care for Children's Mental Health Services:**  
**The First Nine Months of the Fort Bragg Demonstration Project**

*August 18, 1989 - May 31, 1990*

**Executive Summary**

The purpose of this chapter section is twofold: (1) to summarize the major "start-up" activities that were involved in implementing a community-based, continuum of care for children's mental health services (i.e., those efforts that were carried out *prior* to Rumbaugh Mental Health Clinic's official "opening of its doors" to clients on June 1, 1990); and (2) to identify the factors that either facilitated the Demonstration's efforts during its first nine months or erected obstacles to successful implementation. For the most part, this section is based on two sources of information - relevant documents (e.g., minutes of meetings, Project deliverables to the Army, and correspondence) and semi-structured interviews with key State and Rumbaugh staff involved in pre-implementation efforts.

In general, it can be concluded that several of the major tasks required for getting the Demonstration "up and running" were accomplished by the two units responsible for developing the program -- i.e., the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) located within the North Carolina Department of Human Resources and Cardinal Mental Health Group, Inc., through the Rumbaugh Child and Adolescent Mental Health Clinic. As the actual contract awardee, MH/DD/SAS carried out the key managerial activities that culminated in the formal dedication of the Major General James H. Rumbaugh, Jr., Child and Adolescent Mental Health Clinic on May 14, 1990 and its official commencement of providing services to clients on June 1, 1990. Included in these efforts were such prerequisite tasks as acquiring the facility, arranging for a nonprofit corporation to serve as the formal administrative and legal entity for the Demonstration's operations, negotiating funding agreements, establishing mechanisms for monitoring and oversight, and hiring key administrative staff for services planning and management. The Division of MH/DD/SAS also was responsible for arranging that an independent, comprehensive evaluation of the Demonstration was set into motion.

Examining Rumbaugh Mental Health Clinic itself, the majority of "start-up" tasks centered on the creation of the two major organizational segments necessary to implement the continuum of care (i.e., the configuration of clinical services and the administrative structure to support these services). In terms of developing the necessary management structures and support services, significant effort was devoted during the early months of the project to: hiring staff who would administer components of the continuum of care and/or who would deliver services; developing the necessary procedures for accounting, billing, and payment; formulating the numerous policies and procedures required for functioning as a mental health organization; and dealing with various constituencies and community groups (e.g., future referral sources, other local mental health professionals, and the families of CHAMPUS beneficiaries). For the most part, these efforts were successfully completed. Delays did occur, however, in terms of finalizing contracts with local providers, having a functional utilization review system, and having a fully operational management information system by June 1, 1990.

The major components encompassed by the continuum of care -- i.e., a centralized intake assessment system, the array of treatment services, and case management -- also differed as to the "progress" made toward full-scale implementation. As of June 1, 1990, although the intake assessment and outpatient services components were operational, this was not true for each specific treatment option within the continuum (i.e., residential services and community education and treatment). This delay in developing alternative "step-down", residential services was, however, in accordance with the Army's instructions set forth during contract negotiations, based on its expectation about the level of demand for these interventions.

Factors that facilitated the implementation of the Demonstration included:

- (a) The surrounding environment for the Project was rich in resources, including close proximity to relevant state agencies in the state capital and academic institutions;
- (b) The continuum of care was designed to function as an entirely freestanding, nonprofit entity rather than as a unit that was created within an existing provider agency;
- (c) The Project had a sufficient pool of qualified individuals from which to recruit for key staff positions, and the individuals hired represented a complementary mixture of "new blood" and providers who had already well-established networks with other community services;
- (d) Throughout the planning and development phase of the Demonstration, the atmosphere at Rumbaugh was one of teamwork and cooperation, along with a strong embracing of the key philosophies encompassed by the continuum of care, and involved Womack Army Community Hospital personnel were supportive;
- (e) The contract from the Army provided sufficient resources for not only equipment acquisition, facility upgrading, and staff hiring but also for activities instrumental to services delivery, e.g., staff training and resource development; and
- (f) There was a funded "start-up" period for planning and developing the continuum of care and its components.

At the same time, problems arose that hindered to varying degrees the Demonstration's ability to be fully operational by the time it "opened its doors." These included:

- (a) The Demonstration encountered some enmity and mistrust from the local provider community, and their efforts to clear up misconceptions about the Project and enlist provider participation were hampered by delays in releasing relevant information;
- (b) Problems were experienced in installing the computer software chosen to operate the management information system, and consequently, this tracking system for clients, services, and finances was not operational when the Demonstration began accepting clients;

- (c) Due to calculations of expected client flow made during the contract negotiation process resulting in a staggered plan of implementing services, the full continuum of care was not functional by June 1, 1990, and the lack of several "intermediary" treatment settings (e.g., group homes and supervised independent living) restricted the range of "less restrictive" and possibly "less expensive" treatment options for incoming clients.

## **Rationale and Structure of the Chapter Section**

### **Purposes of the chapter**

This section is primarily intended to address two questions frequently asked when reviewing the implementation of any human services innovation. The first issue concerns what was required in terms of money, staff, facilities, and clients for developing and formally launching a functional program. Linked to this question is an assessment of whether this "pre-start-up" phase occurred as planned, particularly in terms of problems that could not be readily resolved and/or that consumed substantial resources in correcting them. And finally, the contextual, organizational, and individual factors that either promoted project planning and development or handicapped these efforts are of interest. As such, this section has two aims:

- (1) It will present a *concise summary* of the key resources expended and actions performed during the "development" phase of the Demonstration (i.e., prior to Rumbaugh's official provision of services on June 1, 1990). Where possible, the *degree of congruence* between these planning and "mobilization" efforts and those originally foreseen by the chief program architects will be discussed.
- (2) The *factors that facilitated or impeded* the progress of the Demonstration during its early stages of development will be identified.

In addition, preliminary insight into the establishment of similar service delivery systems in the future will be provided whenever feasible.

### **Sources of information**

This section is based on two primary sources of information. First, all available documents and materials prepared by the Army, the Division of MH/DD/SAS, Rumbaugh Mental Health Clinic (hereafter referred to as Rumbaugh) and other major constituencies involved with the Demonstration (e.g., local provider groups) were reviewed. These included: all quarterly reports submitted to the Army by MH/DD/SAS; minutes of meetings such as those of the Project Oversight Committee; organizational charts of Rumbaugh; internal memoranda exchanged by MH/DD/SAS with Rumbaugh and/or HSC; and correspondence from groups with which the Demonstration has had contact.

Second, interviews with key State and Rumbaugh staff were conducted by Evaluation Project staff in May 1990. These interviews focused on eliciting information as to the overall context or environment in which the Demonstration was operating, the types and levels of activities necessary to get the Demonstration "up and running," perceptions and expectations for the Demonstration and its individual components, and the existence of any problems that were experienced and how they were or were not resolved. Where relevant, information gleaned from field office reports and site visit notes prepared by Evaluation Project staff also were utilized.

### **Overall approach guiding this section**

Designed as an appraisal of the first nine months of the Demonstration, this section is based on an underlying view of how mental health organizations are structured in general and the resources, basic decisions, and the elements required to have a program that is ready to provide services to clients (e.g., see Leginski, Croze, Driggers, Dumpman, Geertsen, Kamis-Gould, Namerow, Patton, Wilson, & Wurster, 1989). Those aspects that appear unique to creating a continuum of care in mental health, particularly one that is aimed at children and adolescents and nested within the military health care system, also have been considered in this analysis wherever possible (e.g., Behar, 1988, 1990; Johnson & Fried, 1984; Office of the Assistant Secretary for Defense, 1985).

Similar to most organizations in general (Leginski et al., 1989), establishing and maintaining a mental health organization requires several basic managerial decisions, including those related to *acquiring and allocating Demonstration resources* (e.g., contracting for services and procuring the necessary facilities), *monitoring* the organization's use of these resources, and *accounting* for these resources (i.e., demonstrating that there is some control over these resources through the use of such mechanisms as billing procedures, staff hiring guidelines, and policies governing service delivery). Another major category of decisions involves arriving at summative judgments about the degree to which policies are indeed implemented and enforced and about whether program activities led to the intended results; in the above framework, these have been referred to as *assessment* decisions and involve both *compliance assessments* and *impact assessments*. As can be seen in Figure 1-1, the structure of the Demonstration dictates that these different types of managerial decision responsibilities reside in distinct but interrelated entities: within Rumbaugh Mental Health Clinic (the organization that actually houses and provides all services encompassed by the continuum of care); within Cardinal Mental Health Group, Inc. (that serves as the formal nonprofit administrative entity for Rumbaugh); and within MH/DD/SAS (the state administrative unit that is the actual contractor and overall executor of the Demonstration). Comprising each of these major types of decision categories are decisions about *staff, finances, facilities, and clients*. Which entities are involved in these determinations depends, of course, on the particular situation or issue.

## Structure of the chapter

This section is organized into two major sub-sections. The first sub-section provides a general overview of the Demonstration and summarizes its major activities from August 18, 1989 to May 31, 1990 (the nine months prior to Rumbaugh officially "opening its doors" to clients). The purpose of this section is to provide an abbreviated description of the Demonstration's major activities during this period. Information also is presented about each key element of the Demonstration, particularly in terms of the individual components that comprise the continuum of care.

In examining the individual components of the continuum of care, an effort has been made to judge the "degree" (e.g., Palumbo, Maynard-Moody, & Wright, 1984) to which each was actually "prepared" to receive clients on June 1, 1990. Given that the Demonstration is one of the few attempts to actually develop and implement a continuum of care, few standards or criteria are available, against which to judge successful implementation. As such, the original contract with the Army has been used as the chief "standard" for what should have occurred prior to Demonstration "start-up." Where appropriate, other relevant documents that specified modifications (e.g., new time lines) also were considered.<sup>1</sup>

In the final sub-section, factors that contributed to the Demonstration's development of a continuum of care are discussed, along with problems that were encountered that hindered implementation. It should be noted that, for the most part, these did not constitute major obstacles; in many cases, steps were taken to ameliorate concerns and resolve troublesome issues.

Finally, the reader should keep in mind that the majority of this analysis is focused on the organizational aspect of Demonstration "implementation" efforts. Issues related to the development of interorganizational linkages and the building of community support have received at best scant attention. This is partly attributable to the fact that these latter efforts assume increasing importance once the continuum of care is fully operational and once the community (e.g., clients) has had contact with the Demonstration and thus some basis for endorsement or withholding of support.

## Overview of the Fort Bragg Child and Adolescent Mental health Demonstration Project

The Demonstration was initiated by Dr. Lenore Behar under the auspices of the Division of MH/DD/SAS, a unit within the.<sup>2</sup> Funded through a contract awarded to MH/DD/SAS by the U.S. Army's Health Services Command (HSC), the Demonstration is designed to test:

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<sup>1</sup>This point needs to be kept in mind when reading this section, given that several significant events occurred after June 1, 1990 that brought into question the "preparedness" of the Demonstration. Some of these events definitely could not have been planned for (e.g., Operation Desert Shield) while others might have been more quickly foreseen and remedial actions undertaken. These problems, however, will be more completely addressed in the next section summarizing the demonstration's first period of actual operation.

<sup>2</sup>A historical sketch of the activities that led to the contract is provided in Behar (December, 1989).

"the efficacy of a Federal and State contract for providing a case management based alternative delivery system of mental health services tailored to individual patient needs featuring the use of a full continuum of community based services . . . [and] to demonstrate that this continuum of services will result in improved treatment outcomes while the cost of care per client is decreased when compared to current CHAMPUS costs." (HSC Acquisition Agency, 1989, p. C-1)

In contrast to the mental health services typically covered by CHAMPUS and geographically accessible to children of military personnel (i.e., inpatient hospital treatment, residential treatment, and outpatient individual and family treatment), the ingredients of the Fort Bragg continuum of care, in addition to the traditional services described above, can be summarized as including: (a) a broader range of residential treatment settings designed to serve individuals in the "most normalized" environment possible, thus fostering gradual reintegration into the community; (b) day treatment programs, ranging from intensive, full-day activities to afterschool programs; (c) additional outpatient services, including in-school support services and emergency services; and (d) family preservation activities (in-home crisis stabilization). A more detailed listing is presented in Figure 2-1.

Further, in contrast to the existing system of care for military dependents that has been viewed as limited, fragmented, and lacking in coordination, the Project's structure incorporates individualized, on-going case management, a centralized point of intake for all clients (regardless of the type of treatment needed), and a comprehensive and individualized assessment and treatment approach in which the needs of the child dictate services rather than vice versa. In essence:

"The continuum of care approach is child-centered and family-focused. Services are designed and "wrapped" around the child and family, instead of expecting the family to conform to the existing system. Care is delivered in the least restrictive setting possible". (North Carolina Department of Human Resources, April 18, 1990, p. 11).

A more detailed elaboration of this mental health services orientation is presented in Figure 2-2, which outlines the treatment philosophy espoused by the Demonstration.

*Figure 2-1*  
**Mental Health Services Provided and Paid For  
by the Fort Bragg Demonstration Project**

- Outpatient or inpatient mental health services in CHAMPUS authorized general or psychiatric hospitals, residential treatment centers, or specialized treatment facilities.
- Services rendered by qualified providers (e.g., psychiatrists, clinical psychologists, clinical social workers, and other mental health professionals) in diagnosing or treating a covered mental health disorder.
- Individual, group, and family or conjoint psychotherapy.
- Psychological testing and assessment.
- Medical evaluation and testing deemed necessary to assess the client's clinical time at the time of admission or intake.
- Administration of psychotropic drugs.
- Services to parents necessary to support child's or adolescent's treatments (i.e., collateral visits).
- Ancillary therapies when included in an approved treatment plan.
- ♠ Respite services.
- ♠ Independent living for adolescents older than 16 years of age (family involvement in treatment is required).
- ♠ Alternative family living arrangements provided by specialty trained staff in a licensed home.
- ♠ Residential group living services in licensed and professionally supervised community residential setting.
- ♠ Crisis stabilization in qualified, professionally supervised residential setting other than a hospital (7 or fewer days).
- ♠ Day treatment.
- ♠ In-home services by licensed and/or certified professionals.
- ♠ Clinical case management.
- ♠ Partial hospitalization.
- ♠ Transportation to various treatment settings and/or care provided outside the catchment area, based on clinical and social-economic need.
- ♠ Prescription medications.

*Source: Fort Bragg Child and Adolescent Mental Health Demonstration Project Beneficiary Handbook.*

- ♠ "New" demonstration services that are not traditionally covered by CHAMPUS benefits.

**Figure 2-2**  
**Key Elements of the Treatment Philosophy of**  
**the Fort Bragg Demonstration Project**

- ◆ The appropriate locus of mental health services for children/adolescents and their families is their community.
- ◆ Effective services must be linked into a *coordinated* system of care that includes all services ranging from the least restrictive and intensive to the most restrictive and intensive.
- ◆ Mental health services to children and adolescents should be provided in the least restrictive, most normal environment that can meet their needs.
- ◆ Mental health services should be matched to the needs of the child/adolescent.
- ◆ The client's family must aid and be involved in the client's treatment for sustained recovery and continued growth.
- ◆ Educational intervention and support is often needed so that the child's sense of competence and self-worth can be enhanced and/or regained.
- ◆ Once active treatment has been completed, the child and his/her family must be linked to ongoing support structures in the community to help maintain health functioning.
- ◆ Because healthy emotional functioning is dependent on sound peer relationships, it is important to provide services that can help children/adolescents build strong relationships with their friends and peers.
- ◆ For successful progress in treatment, it is necessary that the client understand the need to assume personal responsibility rather than blaming of problems on others.
- ◆ The Demonstration Project has the responsibility to treat all emotionally disturbed children, even those that are often viewed as "untreatable" due to multiple problems, history of past difficulties, and so forth.
- ◆ Relapses are viewed as opportunities for increasing understanding of a child's or adolescent's problems and continued progress in overcoming these problems.
- ◆ Flexible funding and staffing are essential for delivering services that are tailored to the needs of clients.
- ◆ Qualified professionals from multiple mental health disciplines are needed to provide clinical services that are both creative and collaborative.
- ◆ Monitoring of and feedback on program effectiveness is crucial.
- ◆ Supervision, consultation, and training are viewed as vital components for delivering high quality mental health services.

*Source: Treatment Philosophy of Cardinal Mental Health Group, Inc.*

The Demonstration itself is geographically situated in Fayetteville, NC near the Fort Bragg Army post. It is administratively situated in its own nonprofit corporation, Cardinal Mental Health Group, Inc. (Cardinal, Inc.), which has a separate Board of Directors (see Figure 2-3). The Division of MH/DD/SAS in the North Carolina Department of Human Resources has primary programmatic and fiscal responsibility for the Demonstration and its independent evaluation. In accordance with contract stipulations, there also is a Demonstration Oversight Committee (POC) chosen to represent key constituencies and/or supply specialized expertise: three representatives from the Womack Army Community Hospital; one representative from Headquarters, Health Service Command; one representative chosen by the Contracting Officer; four representatives of the Demonstration (the Project Manager, Site Manager, Program Director, and Medical Director); an advisor from Pope Air Force Base Clinic; and the Project Quality Assurance Administrator who also serves in an advisory capacity. A MH/DD/SA area program was designated, by contract, as a funding flow-through agency between MH/DD/SAS and Cardinal, Inc., but was not accorded any major administrative or programmatic responsibility.

The actual locus of services is Rumbaugh, operated by Cardinal, Inc. Under the conditions of the award, the duration of the Demonstration is scheduled to be 57 months (i.e., from August 18, 1989 to June 30, 1994), including a nine-month period for planning and development. Based on the expectation that the project would serve approximately 3% of the then estimated 36,000 children in the catchment area or 1080 children per year, the original award from HSC for the Demonstration totaled \$25,095,144 across the 57-month period. These funds were distributed across several major functions: clinical services; state and local administrative and equipment costs; and an independent evaluation of the Demonstration's effectiveness.

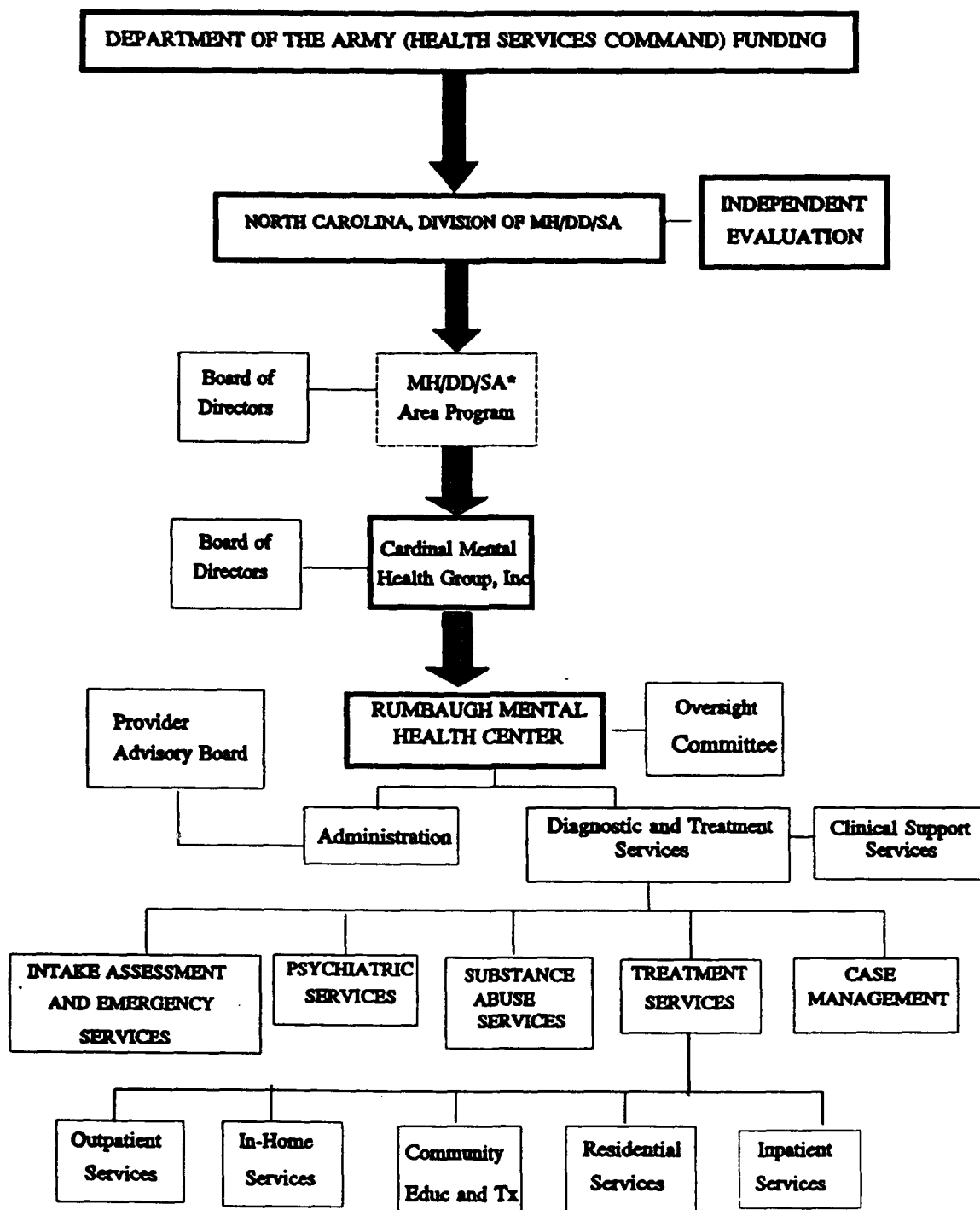
The organizational structure of the Rumbaugh itself, similar to most mental health facilities, is comprised of two distinct components: (1) the actual mental health services themselves that are composed of *intake assessment and emergency*, *treatment* (inpatient, residential, partial day, outpatient, and in-home/emergency services), *psychiatric* and *substance abuse* services available in any treatment setting, and *case management*; and (2) the administrative and support structures necessary to allow these direct services to be provided to clients (see Figure 2-3). The staff and facilities involved in providing treatment services include both Rumbaugh staff and community providers contracted by Rumbaugh for specific activities (e.g., outpatient psychotherapy, emergency services, and inpatient hospitalization). What is unique about this organizational structure in terms of providing a continuum of care is that Rumbaugh serves as the overall coordinator, fiscal intermediary, quality assurance monitor, and umbrella organization for mental health services provided to CHAMPUS beneficiaries in the area. For example, Rumbaugh (rather than Blue Cross/Blue Shield or other designated agencies such as Health Management Services) is responsible for pre-authorizing services and for carrying out utilization reviews via its individual Treatment Teams and its more formal quality assurance process. It also is in charge of providing needed mental health services -- either by assigning its own in-house treatment staff or by making arrangements with outside providers -- and negotiating reimbursement rates.

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<sup>3</sup>Committee membership consists of "members" who have voting rights and "advisors" who are chosen to provide particular input or assistance but who cannot vote.

# Organization of the Demonstration Project

Figure 2-3



\* Note: The MH/DD/SA area program is a funding, but not administrative, flow-through agency. —

## Major Activities of the Demonstration During the First Nine Months

The composite picture of the Demonstration's activities prior to implementing a continuum of care on June 1, 1990 can be organized around five types of managerial decisions/actions as outlined previously (Leginski et al., 1989):

- (1) *Acquiring the necessary resources for the Demonstration.* This includes those actions aimed at procuring needed resources, including financing, staff, facilities, and even clients. Examples are preparing budgets, hiring staff, contracting with local providers to deliver services, developing referral sources, and making arrangements with various third-party payers for services.
- (2) *Distributing resources.* These types of decisions and activities center on the allocation of resources among the various units/groups involved. Typical efforts include negotiating unanticipated requests that involve financial implications, and deciding on specific contractual arrangements (e.g., establishment of reimbursement rates for external providers).
- (3) *Monitoring how resources are utilized.* Decisions and duties required for overseeing resource consumption within the Demonstration cover several different domains. These include, to name a few, the development of formal reporting requirements, review of reports, and the installation of a management information system that can generate and monitor "key indicators" of effort and resources expended by the organization.
- (4) *Accounting of resources.* This category of activities involves those tasks and decisions that demonstrate control over resource utilization. In addition to financial accounting practices, accountability efforts frequently entail the formulation of policies about staff performance and clinical treatment.
- (5) *Assessment of resources.* As previously described, these activities focus on determining whether organizational inputs and outputs are appropriate. Assessments are of two types. Compliance assessments involve making judgments about whether things actually occurred or were supposed to happen as a result of certain organizational actions (e.g., an increase in the hiring of minorities as a result of new agency guidelines or improvements in services delivery subsequent to changes in the allocation of program resources). Impact assessments are directed at determining whether particular expenditures of an organization's resources produced the desired outcome(s), e.g. enhanced levels of client functioning as the result of treatment.

Figure 2-4 presents a detailed enumeration of the major actions taken by the Demonstration, including those carried out by MH/DD/SAS and Rumbaugh.<sup>4</sup> Briefly stated, the majority of activities during the nine-month period were directed at acquiring resources, distributing them among participants, and developing monitoring and accounting procedures for tracking how these resources were allocated and expended. The major efforts under each of these more general categories are briefly described following Figure 2-4.

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<sup>4</sup> The activities that occurred under the auspices of the Evaluation Project are not detailed in this report, given that this document is part of the overall evaluation effort at Vanderbilt University.

**Figure 2-4**  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**August 18, 1989 - May 30, 1990**

**Acquisition of Resources**

- ◆ Initiated and finalized the incorporation of Cardinal Mental Health Group as a nonprofit corporation and obtained appropriate tax exempt status
- ◆ Obtained necessary licenses and certificates of insurance for Cardinal
- ◆ Recruited and hired individuals for staff positions at:
  - Division of MH/DD/SAS ( $n = 4$ )
    - Two project managers, one project accountant, and one secretary
  - Rumbaugh Mental Health Clinic ( $n = 35$ )
    - Executive Director, Medical Director, Program Director, Assistant Program Director, Quality Assurance Administrator, Accounting/Business Manager, Training Coordinator, four business staff, three Medical Services staff, 16 clinical services staff, and 5 clinical support staff  
[Note: More positions were authorized but had not yet been filled.]
- ◆ Purchased necessary capital equipment and supplies:
  - Data processing equipment and software
  - Office equipment (e.g., FAX machines, mailroom equipment, audiovisual equipment)
  - Furniture for staff offices and lounge, play therapy room, waiting room, clinical staffing room, and family therapy room
- ◆ Located and rented both temporary space and permanent facility
- ◆ Upfitted building (e.g., installation of telephone and dictation/transcription systems, wiring for data processing system, installation of PC network and computer hardware/software)
- ◆ Obtained required licenses and program certifications for Rumbaugh
- ◆ Arranged for appropriate resources (both experts and library services) for staff training
- ◆ Completed the process of developing transition plans for 120 project-eligible clients

*Figure 2-4 (continued)*  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**August 18, 1989 - May 30, 1990**

**Acquisition of Resources (continued)**

- ◆ Disseminated information about the Demonstration Project to providers and clients through:
  - Media coverage (television, post/base newspapers, posters to relevant organizations on the post and base, and base bulletins)
  - Briefings for local professional groups (e.g., Womack Army Community Hospital, local medical society, family practice physicians, and Developmental Evaluation Center)
  - Meetings with local referral sources to explain the Project and their possible involvement as a contractee
  - Individual mailings, including a Project-developed informational pamphlet, to 350 community providers who might be interested in participating in the Demonstration through contractual agreements
  - Beneficiary workshops
  - Meetings with other key community groups
- ◆ Attended meetings to develop working relationships with referral sources at:
  - Dept. of Pediatrics, Womack Hospital
  - Dept. of Family Practice, Womack Hospital
  - Local community pediatricians, Cape Fear Valley Medical Center
  - Multidisciplinary Family Teams, Fort Bragg and Pope Air Force Base
- ◆ Involved in efforts transition clients to the new system of care:
  - Requested information from 350 community providers concerning the number of Project-eligible clients they were treating and the number they anticipated would still require services after June 1, 1990
- ◆ Developed "boiler plates" for private provider contracts with Rumbaugh
- ◆ Initiated and completed negotiations for procuring outside clinical services from:
  - Cumberland Hospital and other hospitals
  - Individual and group practitioners
  - Contact of Fayetteville (after hours, weekends, and holidays telephone screening services)
- ◆ Made arrangements for MH/DD/SA area program to act as funding "flow-through" agency
- ◆ Completed final budget

*Figure 2-4 (continued)*  
**Major Actions Taken By the Fort Bragg Demonstration Project:  
August 18, 1989 - May 30, 1990**

**Distribution of Resources**

- ◆ Determined rate schedules for contracted providers
- ◆ Finalized subcontract for HMS to handle authorization and appropriateness of covered provider services for the period January 1 - May 31, 1990
- ◆ Developed internal procedures for reimbursing subcontractors, including practices that would allow advancing \$500,000 from the State to Cardinal for initial Project activities
- ◆ Approved staff participation in several in-house and external training opportunities

**Monitoring Utilization of Resources**

- ◆ Created Project Oversight Committee composed of representatives from MH/DD/SAS, Rumbaugh Mental Health Clinics, and Womack Army Community Hospital (WACH)
  - Developed the policies and procedures for its functioning
- ◆ Development of quarterly report requirements to document and relay information about Project activities
- ◆ Initiated periodic site visits by MH/DD/SAS for the purposes of monitoring the Demonstration and Evaluation Project
- ◆ Initiated a schedule of weekly telephone conversations by MH/DD/SAS to Rumbaugh and Vanderbilt for the purposes of information collection and oversight

*Figure 2-4 (continued)*  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**August 18, 1989 - May 30, 1990**

**Accounting of Resources**

- ◆ Developed policies, procedures, and protocols for Project operation, including:
  - General administrative:
    - Formal plan for marketing and information release
    - Small disadvantaged business plan
    - Rumbaugh staff training plan
    - Policies for hiring, promoting, and terminating professional and nonprofessional staff at Rumbaugh
    - Clinical staff rules and regulations
    - Procedures and schedule for weekly staff orientation
    - Appeals and grievances procedures
    - Voucher and reimbursement procedures
    - Audit guide for independent auditor
    - Transportation plan
  - Services delivery:
    - Diagnostic protocols
    - Methods for handling transitional cases
    - Criteria for determining levels of care
    - Draft beneficiary handbook
- ◆ Developed small-scale computerized data bases for:
  - Tracking Rumbaugh staff training
  - Cataloguing books and journals purchased by Rumbaugh
- ◆ Began implementation of the financial and client management information systems
- ◆ Established key policy committees at Rumbaugh:
  - Credentials Committee
  - Clinical Records Committee
  - Utilization Review Committee
  - Quality Improvement Committee
- ◆ Participated in the Project audit carried out by HSC and the Defense Contract Audit Agency

**Assessment of Resources**

- ◆ Completed negotiations for contract with Vanderbilt University to evaluate the impact of the Demonstration Project

### Acquisition of resources

A significant portion of the "mobilization" phase of the Demonstration was spent in efforts aimed at acquiring resources in terms of facilities, equipment, staff, and services. During the first nine months, staff in both MH/DD/SAS and Rumbaugh devoted significant effort to:

Acquiring funds. In order to fund the development and implementation of a continuum of care, a legal and administrative entity was needed so that funding could be channeled to services provision and administration. Moreover, such an entity was needed so that the appropriate licenses, certifications, and other requirements in order to be legally functional could be obtained. At the beginning, the decision was to situate the Demonstration in a separate nonprofit entity rather than to operate it within an existing public or private agency. One of the bases of this decision was the belief that public agencies had to satisfy a plethora of regulations and bureaucratic practices, which would serve to reduce the flexibility needed to implement an innovation.

Another related decision made by those charged with developing the Demonstration was to take advantage of an existing opportunity -- i.e., to make use of the background knowledge of a nonprofit corporation that had previously been established and indeed operated to approve "certificates of need," but that was no longer operational (i.e., Cardinal Health Systems Agency). Using many of the same members who brought with them a wealth of background information and community networking, rather than "starting from scratch" Cardinal Mental Health Group, Inc. was incorporated. This strategy appeared beneficial for two major reasons: (1) it reduced the time needed to formally establish such a corporation if beginning anew (e.g., preparation of the necessary paperwork); and (2) it provided the Demonstration with the political, administrative, and community expertise by having access to and ultimately involving individuals who previously had been affiliated with the "certificate of need" process and the previous corporation.

To complicate funding arrangements, however, there was a state statute that required "funds from the United States Department of Defense for the purpose of operating mental health demonstration projects for families of the uniformed services . . . to be operated through an area authority" [General Statute 122C-112(b)(8)]. This provision prevented funds for the Demonstration itself (i.e., Rumbaugh) from being directly awarded by MH/DD/SAS. Rather, they had to "flow through" a MH/DD/SA area program that would then contract with Cardinal, Inc., to provide the requisite services and also monitor expenditures. Although not an onerous task "on paper," finalizing this arrangement proved more difficult than initially expected due to several factors. For example, the original plan was to involve a MH/DD/SA area program in close proximity to Rumbaugh so that operation and oversight (e.g., financial monitoring) would be facilitated. At the same time, Cardinal itself planned to contract for selected clinical services (e.g., emergency services) with providers in the surrounding community so that these treatment options would be easily accessible to the client; it was thought that such arrangements also would help in compensating providers for "lost" revenue from CHAMPUS clients that might be associated with the advent of the Demonstration. Thus, this situation meant that the area program that would monitor Rumbaugh *could not* also be used as part of the continuum of care if the potential for conflicts of interest was to be avoided. These factors, coupled with difficulties engendered by local personalities and concerns, resulted in three MH/DD/SA area programs (Cumberland, Blue Ridge, and Lee-Harnett) being approached before a formal arrangement was realized in late June 1990.

In addition, given that this was a newly instituted statute, it was the case that the actual procedures and modes of operation for implementing this statute had to be developed "ad hoc" to deal with issues that surfaced during attempts to implement this statute.

Developing contractual arrangements. Substantial effort also was expended by both State and Rumbaugh administrative staff in developing contractual arrangements with local providers for procuring selected services that were part of the continuum of care (e.g., inpatient hospitalization and outpatient psychotherapy). It was expected that about 67% of all cases admitted by Rumbaugh would be referred out to other providers in the community for services and reimbursement by Rumbaugh.

The process of identifying and contacting providers, soliciting interest, providing information, and preparing actual contracts proved, however, to be lengthier than anticipated. In fact, two weeks before Rumbaugh began providing services, there were no signed contracts, although approximately 20 were awaiting signature.

Satisfying the necessary requirements for licensing and certification. Another major responsibility involved activities related to ensuring that Rumbaugh could meet all necessary licensure and certification requirements (e.g., for outpatient and substance abuse services), along with additional state standards and those of the JCAHO. Further, several other requirements had to be met, including obtaining insurance and assuring that all Rumbaugh staff met the necessary licensing and credential standards.

Locating and arranging for facilities. Locating an appropriate facility for the Demonstration was, relatively speaking, accomplished fairly easily. A site (Omni Centre) within close distance to the Army post, the major outpatient health care clinic for Army personnel (PRIMUS), and public transportation was found early on in the Demonstration. Another added benefit was that this site did not require extensive upgrading or renovation, although some "up-fitting" and improvements (e.g., a play therapy room) needed to be made. The facility was, however, essentially ready for administrative staff use by early 1990.

Hiring staff. Considerable effort, particularly by key Rumbaugh administrative staff, was spent in recruiting and hiring qualified staff for the Demonstration. To facilitate this process, a computerized data base on applicants ( $n = 400$  as of May 1990) was developed to assist in keeping track of applicants, assuring that required hiring tasks (e.g., acknowledgement letters) were completed, and identifying qualified applicants as additional positions became open.

In general, Rumbaugh staff felt that they had been successful in hiring individuals with excellent qualifications, but that this achievement was only accomplished by substantial time and effort to overcome such factors as the geographic location of Fayetteville and the "time-limited" nature of staff positions associated with demonstration projects. At the same time, there were several attractive features of the Demonstration that aided recruiting, including its proximity and ties to the University of North Carolina at Chapel Hill. In addition, there was somewhat more flexibility in setting salaries; although Rumbaugh's salary schedule was only slightly higher than that of other major public facilities in the area (i.e., 1.2%), individuals could be hired at "steps" other than "Step 1", i.e., at a salary in the middle of the range for a particular grade.

Arranging for clinical services. Efforts aimed at disseminating information about the Demonstration in order to alert the Demonstration's potential clients about the new system that would begin on June 1st also were required. During the first nine months of the Demonstration, several activities were carried out: an information release campaign to local and post media regarding the official dedication ceremonies of Rumbaugh; presentations describing the Demonstration by Rumbaugh staff to school systems, providers groups, and referral sources; the conduct of two workshops for interested beneficiaries; the preparation of fact sheets and letters to on-post organizations (e.g., youth activities and family services centers); and the development of a "beneficiary handbook" for clients.<sup>5</sup>

Further, policies and procedures had to be instituted in order to ensure that clients already in treatment under the existing system were: (a) "well informed of the changes in the way CHAMPUS mental health benefits were to be provided;" (b) "confident that the changes would enhance or improve services;" and (c) "assured that intrusion and disruption of treatment would be minimal." In order to identify these individuals and facilitate their entry into the continuum of care, the Demonstration planned to: contact about 350 providers, including all MH/DD/SA area programs, JCAHO approved psychiatric hospitals, general hospitals with psychiatric units, residential treatment centers, and all private providers involved in outpatient care in the immediate service delivery area; review cases; develop formal transition policies; and prepare individualized transition plans for project-eligible clients.

These transition activities required more time than expected for several reasons. First, nearly 1,000 ( $n = 974$ ) providers had to be contacted to identify project-eligible clients. This resulted in 302 clients being identified as receiving mental services prior to June 1, 1990 and as needing services after this date. Further, the review of cases and preparation of individualized transition plans during the period January - June 1, 1990 by Rumbaugh staff was quite labor-intensive. For example, the Transition Team responsible for reviewing the needs of these individuals was meeting four days per week near the end of this period. The total cost of staff time necessary for these transition activities was estimated to be \$103,500, including 25% time for five months for three senior clinicians and a staff member, 100% time for three months of three case managers, and 1.7 FTE of support staff.

#### **Distribution of resources**

As the various resources were procured, decisions were made regarding how they would be allocated to the various administrative/support and treatment components of the Demonstration. For the most part, during the nine month start-up, this involved activities related to distribution of funds. For example, a final budget for each component of the continuum of care and the Demonstration as a whole had to be prepared. Internal procedures for reimbursing subcontractors (including making provisions for the State to advance \$500,000 for Demonstration activities until these costs could be billed to and reimbursed by the Army) had to be developed. Reimbursement rates had to be established for paying contracted providers.

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<sup>5</sup>This beneficiary handbook was not made available to clients until the summer of 1990 due to the need to await Army approval for necessary changes in various clinical policies.

In addition, a complication arose regarding the transfer of CHAMPUS responsibilities during this time period. Given that the new system of care bestowed upon Rumbaugh, in addition to service delivery, the role of precertifying all inpatient and residential treatment admissions and performing utilization review for long-term outpatient care, commencing during the start-up period, provisions had to be made for performing this responsibility until Rumbaugh was to be opened. Service delivery was not scheduled to commence until June 1, 1990, yet precertification was required for children in this catchment area beginning January 1, 1990. Consequently, a contract had to be finalized between MH/DD/SAS and HMS that has authorization and appropriateness determinations for all mental health services outside of the catchment areas of demonstration projects being billed to CHAMPUS.

#### **Monitoring utilization and accounting of resources**

Developing sound monitoring and accounting systems also constituted a major activity during the first nine months of the Demonstration. An oversight group (the POC) that was comprised of all the major constituencies for the Demonstration had to be established; its first meeting was held January 17, 1990, and formal operating policies and procedures emerged shortly thereafter. At the state administrative level, several activities were initiated, including both periodic site visits and weekly telephone briefings.

Financial monitoring. Administrative staff at both Rumbaugh and MH/DD/SAS also were heavily involved in developing policies, procedures, and guidelines for monitoring fund acquisitions and expenditures (e.g., voucher and reimbursement procedures and audit guidelines). These regulations and guidelines themselves had to satisfy other major standards and requirements (e.g., those that apply to receiving a federal contract, state policies, general accounting principles for nonprofit private organizations, and rules of the MH/DD/SA area program through which funding was being channeled. Along with these tasks were additional ones associated with developing "boiler plate" specifications for contracts with outside providers and other groups).

Staff monitoring. Several efforts linked to monitoring staff conduct also were initiated. These included, to name a few, the development of mechanisms for tracking and overseeing staff training activities, the preparation of clinical staff rules and regulations, and procedures for handling appeals and grievances.

Services monitoring. Not surprisingly, a significant amount of effort revolved around formulating policies and procedures related to the services delivery function (e.g., diagnostic protocols, methods for handling transitional cases, and criteria for determining levels of care). In addition, Rumbaugh created several key policy committees, including ones for credential review, clinical records maintenance, and utilization review. It should be noted that the utilization review procedures were not fully operational at the time of the project's "start date." Although this quality assurance program was to be ongoing on a monthly basis as of June 1, 1990, this was not the case.

Several other clinical services policies and procedures had to be developed. These included developing procedures for paying for prescription medication for clients served by the Demonstration and determining the eligibility of emancipated minors for participation in the project. Another general responsibility involved the design and implementation of the financial and clinical client management information systems (MIS). During the first nine months of the

project, considerable attention was devoted to choosing an appropriate software and getting the system "up and running." However, the MIS was not fully operational at the time Rumbaugh began providing services; the financial and clinical components were only partially automated.

### **Assessment of resources**

Finally, to assess major outcomes and effects associated with the Demonstration, a contract with Vanderbilt University was finalized. Their contract provided for an independent team of researchers to determine whether: (1) the Demonstration resulted in improved mental health outcomes for its participants above those experienced in the comparison sites using the existing CHAMPUS service delivery system, and (2) the services provided by the Demonstration were more cost-effective. Internally, Rumbaugh also began work developing its own Utilization Review System to monitor and assess the quality of services it was providing. Although the establishment of systems to assess the performance of the organization is considered a monitoring function, these activities are noted here to document the attention to planning for future assessment activities during the start-up period.

### **The Continuum of Care and Its Components**

The preceding paragraphs have focused on providing a picture of the Demonstration overall in terms of "pre-start-up" activities. However, the actual clinical services to be provided in the continuum of care are comprised of several individual components: (1) intake assessment and emergency services; (2) treatment, including inpatient, residential, partial day, outpatient, and emergency/crisis services; and (3) case management. As of June 1, 1990, the degree to which each of these were implemented was not uniform.

It should be noted at the onset that the judgment of "preparedness" has been made based on the client flow anticipated by Rumbaugh at the point it began providing services. This expected level of demand was based on information provided by HSC and thus was incorporated into the contract as the standard for hiring sufficient numbers of staff. As indicated in the original contract, the initial months of service delivery were based on a specific number of clients (Hiring Plan A) (see Table 2-1), and during the course of the Demonstration, staff increases were planned as client demand accelerated (Hiring Plans B-D).

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Table 2-1  
Cardinal Staffing Plan for FY89/90

Plan/ Date	Predicted Client Load	Planned Number of Clinic Staff
A/August 1989 - May 1990	160-200	40
B/June 1990 -September 1990	240-300	50
C/October 1990-September 1991	320-400	60
D/October 1991 - May 1994	400-500	69

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In describing the level of "preparedness" for each of the components (see Figure 2-5), a strategy has been adopted in which each component has been judged to be "generally equipped", "partially equipped", or "not equipped at all" to be providing services to individual clients and their families. The basis for these judgments resides in meeting the following criteria: (1) all staff (included in Plan A) have been hired and are in place; (2) the necessary facilities are operational; and (3) the requisite policies, procedures, and clinical tools have been developed for services provision. To warrant the judgement of "not equipped at all" requires that none of the three criteria has been met; satisfying two of the three criteria merits a rating of "partially equipped;" and "generally equipped," means that all three criteria have been achieved, although some fine-tuning may still be necessary. This classification system is recognized as fairly crude and assumes that each of the three criteria are equally important. At the same time, it is believed that this provides a useful approach to summarizing the status of the continuum of care on June 1, 1990. Figure 2-5 provides a pictorial synopsis of each component's "state of readiness."

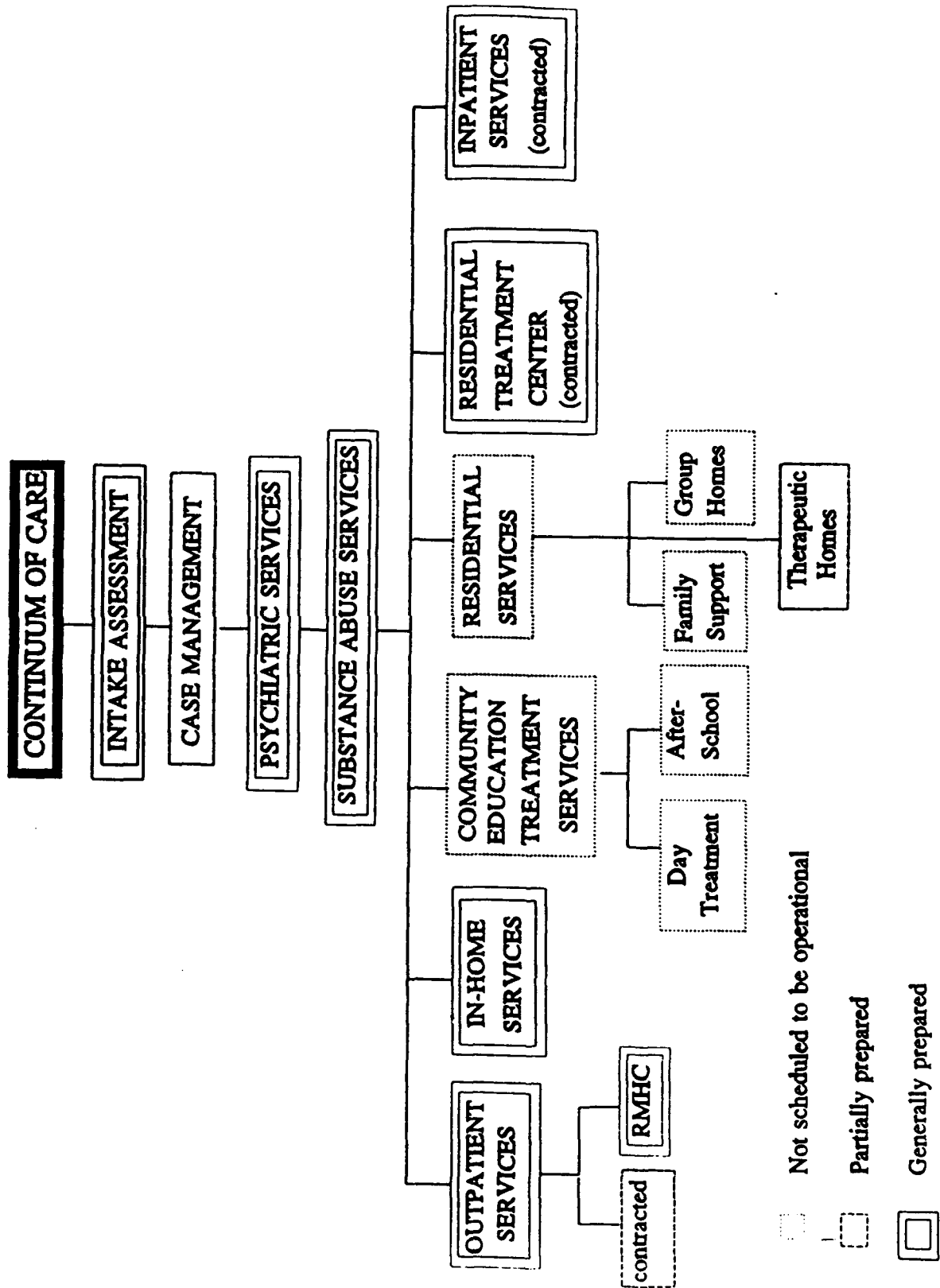
Intake Assessment. The Intake Assessment and Emergency Services section was generally equipped to begin its clinical efforts. A Section Head was hired (although relatively new), the number of staff specified by Hiring Plan A were trained and in place, contracts for outside services (i.e., crisis line screening and emergency services) had been finalized, and the requisite office space was provided. In addition, the decisions about the diagnostic procedures and protocols had generally been completed, and work had begun in terms of linking with local mental health agencies to deal with issues of transitioning clients.

In general, few problems surfaced with regard to developing this component of the continuum of care prior to June 1, 1990. Compared to the ease of recruiting individuals to other Rumbaugh units, some difficulty resulted from the fact that many individuals qualified for intake positions also are trained to conduct psychotherapy and did not wish to focus solely on client intakes. However, this issue was handled by exploring with the Outpatient Services section the possibility that intake staff also could provide treatment to 1-2 clients.

Outpatient Services. In general, Outpatient Services was ready to deal with clients as of June 1, 1990. All Rumbaugh staff had been hired (as specified in Plan A), there was a Section Head to administer the component, and approximately 20 contracts were awaiting signature with outside providers. The necessary facilities were available (e.g., staff offices and the therapy/observation rooms). Specific procedures for how contracted providers would function in the system of care (e.g., their role at Treatment Planning meetings) still needed to be formalized, along with other issues of concern to this group (e.g., whether contracted providers would be reimbursed for time spent on report completion). In hindsight, it would have been preferable to have had these procedures developed, given the substantial reliance on contracted professionals resulting from the heavier-than-anticipated client flow after June 1st and the 219 transition clients treated by outpatient providers.

In-home Services. By June 1, 1990, the Section Head had been hired, along with the staff specified by Plan A. Further, policies regarding admission and continuation criteria for the delivery of emergency services, operation standards for this component, and other related issues were either developed or in the process of being developed.

Figure 2-5  
 Ft. Bragg Demonstration Project  
 Preparedness of Components on June 1, 1990



Day Treatment Services (CETS). The Community Education and Treatment Services section was not in place by the time the Demonstration began treating clients, although such services as in-school therapeutic assistance and school consultation were available to clients soon thereafter. CETS programming was not scheduled to begin on June 1, 1990, as the Army wanted to make sure that the demand was sufficient to warrant full-scale implementation. However, one full-time clinician and a part-time consultant who specialized in day treatment were developing initial section guidelines in anticipation of implementation. As such, the Day Treatment program had not been established and in fact was still at the conceptual stage. At the same time, this component appears "underprepared" in general. The Section Head position had not been filled, along with such other positions specified by Plan A as Curriculum Specialist. Initial efforts to forge strong linkages with the schools and other relevant community providers had begun but were awaiting the filling of the Section head position.

Residential Services. This component also was not implemented as of June 1, 1990, but was not scheduled to be implemented at that time, resulting from the Army's decision to postpone operation until FY 1991. Plans were underway for the development of these services, however. A Section Head had been hired, and efforts were being made to fill other staff positions; in fact, as of late May 1990, screening of almost 200 applicants for 7 group home positions was underway. The therapeutic home program and group homes were in the early stages of planning and development stages, but appropriate locations for these residences had not been found. As of June 1, 1990, however, existing community therapeutic homes and group homes were available as needed on a contractual basis. It was planned that the therapeutic home program would be fully operational by October, with no date at that time determined for the implementation of group homes.

Case Management. Case management services at Rumbaugh appear to have been only partially equipped for their function. Although the Section Head and the requisite number of staff had been hired as dictated by Plan A, several procedures and policies still needed to be finalized. For example, the model of case management to be used by Rumbaugh was generally articulated in documents describing the phases of the managed care function, and the curricula for training case managers were nearing completion. Policies and procedures concerning client eligibility for case management, emergency clinical case management procedures, length of case management efforts, and the structure and contents of comprehensive treatment plans also were being developed/had been completed. There is some suggestion, based on relevant materials pertaining to subsequent months (i.e., August 1990 and thereafter), that the "preparedness" of this component could have been bolstered. Within a few months after operation, a new Section Head was hired, and the internal organization of this component was significantly restructured.

The reasons for the later modifications in the case management component, and the implementation of service delivery by the CETS and Residential Services components, will be discussed in a following chapter describing the first thirteen months of service delivery (June 1, 1990 - June 30, 1991).

## **Factors Facilitating or Impeding Planning and Development of the Demonstration**

There were several factors that facilitated the implementation of the Demonstration. These are more completely described below.

The surrounding environment for the Demonstration was relatively rich in resources, particularly when compared to many other major military installations. Being closely situated to leading research and teaching institutions, state government, and other major mental health resources (e.g., the Area Health Education Center) facilitated such activities as the hiring and training of staff and the acquisition of expert consultation for program/component development. Further, the existence of related initiatives for children (e.g., the Robert Wood Johnson and CASPP projects) can be seen as providing a rare opportunity for services collaboration and cooperation in the area of children's mental health services. The staff in the North Carolina state office provided linkage between these service demonstrations. In addition, state staff members who handled administrative issues relieved Cardinal, of extensive paperwork and served as a buffer between the Demonstration and the Army during this time period.

Another factor that facilitated implementation of the Demonstration concerned its basic organization and configuration as a mental health services organization. At the onset, the continuum of care was both developed by and housed within a "new" freestanding, nonprofit facility rather than being placed within an existing health/mental health agency or governmental bureaucracy. In line with the "lessons" from the literature (e.g., Gray & Scheier, 1987), this helped to provide the flexibility needed to launch new initiatives, and this perspective also surfaced in the May 1990 interviews. For example, the policies and procedures that needed to be developed, while having to conform to state requirements and professional standards, did not have to try and fit with an existing organization's modes of operation; this would have been the case if the Demonstration had been a component/program within an existing community mental health clinic. Also, the nonprofit status of Rumbaugh permitted additional license in hiring personnel; whereas Cardinal had to stay within the general salary schedules of other state/county organizations within the catchment area, it did have the flexibility to more easily hire staff at steps other than the "bottom" step within a specific position grade (e.g., the mid-range). As will be described in a later section, this also led to some problems.

As a result of concerted recruiting efforts, the Demonstration had a sufficient pool of qualified applicants for consideration. Further, the individuals who were selected and hired represented a complementary mixture of "new blood," substantial professional experience, and well-established community contacts. This "blend" was reflected in several ways, and its achievement may be seen as a tribute to those in charge of hiring. For example, the Executive Director of Cardinal had a long history of community contacts and interactions, having served as the chief executive of a former health organization in the catchment area. The Program Director had been practicing in the local area and involved in the planning of the Demonstration for four years prior to the award of the contract. Key management staff were experienced in developing and operating from a system approach following their prior experience in public sector endeavors. This type of expertise facilitated the development of relationships with other groups and organizations. At the same time, Rumbaugh staff also included individuals new to the catchment area, thus offering another perspective regarding contextual events and ways of handling problems.

Throughout the planning and development phase of the Demonstration, the atmosphere at Rumbaugh was one of teamwork and cooperation, along with a strong embracing of the key philosophies encompassed by the continuum of care. This shared commitment and collegial approach bodes well in developing a new program. Staff responses to field interviews in May 1990 indicated that they were quite pleased to be involved in the demonstration, with many saying that "this was the best job they have had." Communication between management and staff also appeared to be bi-directional and effective. A formal Management Team was formed that met regularly to prioritize needs and priorities, develop policies, and communicate these policies to all Rumbaugh staff. Similarly, the support of the WACH command personnel during start-up, and subsequently as members of the POC, facilitated implementation of the Demonstration during this time period.

The contract from the Army provided sufficient resources for not only equipment acquisition, facility upgrading, and staff hiring but also for activities instrumental to services delivery (e.g., staff training and development). This strong emphasis on training is embraced by the overall treatment philosophy of the Demonstration and was viewed quite positively by staff as one that helped them to carry out their responsibilities more successfully. For example, clinical staff were allowed to attend seminars and workshops pertinent to their roles (e.g., workshops on clinical algorithms, therapeutic foster care, and different models of case management). The scheduling of in-house sessions where staff could disseminate materials from workshops they had attended and discuss the highlights of the training also was seen as both broadening the results of training and providing an opportunity for staff discussion and collegiality.

Finally, the existence of a funded "start-up" period for planning and developing the continuum of care and its components was crucial. Although the need for this is obvious, it is not unlikely that individuals are often asked to begin services shortly after the funding becomes available. Given the comprehensive breadth and scope of the Fort Bragg Demonstration process and the multitude of activities that had to be completed, it could be argued that this planning period could have been lengthened.

At the same time, problems surfaced that hindered in one or more ways the Demonstration's ability to be fully operational by the time it "opened its doors." First, the Demonstration encountered some suspicion and mistrust from the local provider community, and its efforts to effectively field questions, correct misunderstandings, and enlist provider participation were hampered by the length of time required to obtain HSC approval to release information (e.g., reimbursement rates for contracted providers) that could have helped to address provider concerns. Consequently, the time and effort to contact and enlist provider participation (e.g., establishing contracts for needed services) was considerably greater than anticipated, and few contractual arrangements were finalized as of June 1st, particularly those with private practitioners. For the most part, however, the level of "hostility" from community providers was low, with the majority of concerns revolving around billing and payment issues, e.g., reimbursement rates, administrative "paperwork" requirements, and "turn-around time" for payment of claims.

The only exception was Cumberland County Mental Health Center, the local MH/DD/SA area program. Repeated concerns were raised by the Area Director, including the salaries offered by Rumbaugh, concern that the demonstration was "raiding" Cumberland staff, and so forth. In

general, these concerns were promptly handled and appear to be overinflated. However, some level of friction persisted, including speculations that key administrative staff at Cumberland had attempted to raise concern over the Demonstration by suggesting to a local newspaper reporter that he should investigate Cardinal's hiring, bidding, and administrative practices.

Problems were experienced in adapting the computer software chosen to operate the management information system to meet the needs at the Rumbaugh Clinic. A pre-existing software program was chosen in order to expedite implementation but did not allow the flexibility needed for this Demonstration. Customization was required that, at times, took longer than anticipated. In addition, fine tuning of the manual system required additional time. As a result, the complete system for client characteristics, service utilization, and financial transactions was not fully operational when the Demonstration officially opened its doors.

As of June 1, 1990, the staffing levels for Rumbaugh were in accordance with Plan A, although a few key positions remained open (e.g., the Section Head for Community Education and Treatment). This staffing plan was based on the Army's assumption that client demand would total between 160 and 200 during the initial months of service delivery.

For several reasons, including the constraints established by HSC, the full continuum of care was not implemented as of June 1, 1990. Coupled with a significantly heavier client load and the lack of several "intermediary" treatment settings (e.g., group homes and supervised independent living), it became readily apparent that this situation worked against the project's overall goals (i.e., improved treatment outcomes at reduced cost, along with providing "individualized, wrap-around services"). These issues are discussed in the following section, "The First Thirteen Months of Service Delivery of the Fort Bragg Demonstration Project, June 1, 1990 - June 30, 1991."

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<sup>6</sup>Cardinal's salary schedule was only 1.2% higher than Cumberland's. Cardinal, however, was able to hire staff at higher "steps," thus effectively increasing the salary levels.

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**Section 2**  
**Providing a Continuum of Care for Children's Mental Health Services:**  
**The First Thirteen Months of Service Delivery of the Fort Bragg Demonstration Project**

*June 1, 1990 - June 30, 1991*

**Executive Summary**

The purpose of this chapter section, as in the previous section, is twofold: (1) to summarize the major activities that were involved in implementing a community-based, continuum of care for children's mental health services during the first thirteen months<sup>7</sup> of service delivery of the Fort Bragg Demonstration Project (i.e., the thirteen months following the Rumbaugh Mental Health Clinic's official "opening of its doors" to clients on June 1, 1990); and (2) to identify the factors that either facilitated the Demonstration's efforts during its first year of service delivery or erected barriers to successful implementation. As mentioned previously, this section primarily on two sources of information -- semi-structured interviews with key State, Womack Army Community Hospital, and Rumbaugh staff, and relevant documents (e.g., Project deliverables to the Army, internal correspondence, minutes of meetings).

The major activities were directed at acquiring resources, distributing them throughout the organization and service system, and developing monitoring and accounting procedures for tracking how these resources were allocated and expended. An intense amount of effort continued to be directed to acquiring needed resources. This effort was a result of an immediate surge of request for services that far exceeded planning estimates. Directly related to this issue were increase in the client load, increase in the budget, increase in the staffing plans, and contracting with private providers. As new resources were added to those already in place, decisions regarding how they would be allocated to the various administrative and clinical components of the Demonstration were continually made. This involved not only receiving and distributing funds, but also prioritizing client care and coordinating services and resources.

Continued development of monitoring plans and carrying out of accounting functions also constituted a significant focus during the initial thirteen month period of service delivery. The monitoring activities centered on establishing procedures for overseeing resource consumption at the Demonstration, while the accounting functions followed by documenting the actual performance in the specified areas. The activities associated with assessment of Demonstration resources took two primary forms: (a) evaluation of the level of resources needed to provide services to the eligible clients who presented for care; and (b) assessing the compliance of the Demonstration with requirements imposed by the contract and by the community best-practices doctrine for professional services.

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<sup>7</sup>The thirteen month time period was chosen instead of one year in order to coincide with the end of the quarterly reporting period.

The actual clinical services provided in the continuum of care comprised several components: (a) intake assessment and emergency services; (b) case management; and (c) treatment provided by Rumbaugh and contract providers, including: outpatient, day treatment and afterschool programs, in-home therapy and crisis intervention, residential, inpatient, psychiatric and substance abuse services. At the beginning of this time period, Intake Assessment, Case Management, In-home Services, and Outpatient Services were the only components within Rumbaugh that were operational. Inpatient services and therapeutic homes became available immediately through contract with area programs. Although the remaining components had originally been planned through the budget negotiations process to be phased in, the increased caseload necessitated implementing these services as quickly as possible. By March, 1991, the Community Education Treatment Services and Residential Services components were also fully operational and the continuum was considered complete.

Factors at the organizational, community, and contractual levels influenced the implementation of the Demonstration during the period from June 1, 1990 to June 30, 1991, the first thirteen months of service delivery. Factors that facilitated the implementation of the Demonstration included: (a) Cardinal's organization as a not-for-profit mental health agency and its related administrative flexibility; (b) general organizational flexibility in the face of increasing client loads and change; (c) staff commitment to the continuum of care model; (d) coordination of treatment services at the individual and organizational level; (e) abundant resources; and (f) the presence of two buffering groups between Rumbaugh and the Army Health Services Command (HSC).

Factors that posed impediments to the successful implementation of the Demonstration as planned included: (a) the high volume of clients presenting for service on June 1, 1990, and beyond; (b) the quick expansion of services in addition to the difficulty in initiating alternative services that are not part of the mental health "mainstream" such as day treatment, residential services, and case management; (c) problems regarding role ambiguity, continuity of care, and family involvement with children and adolescents involved in multiple levels of care; and (d) the increasing strain in relationship between the Army and the Demonstration related to rising costs and increased surveillance. The issues raised during this first period of service delivery Demonstration will continue to play out as the second year of service delivery unfolds.

## **Rationale and Structure of the Chapter Section**

### **Purpose of the section**

In general, this chapter is intended to continue the description Demonstration begun in the previous section, "Developing a Continuum of Care for Children's Mental Health Services: The First Nine Months of the Fort Bragg Demonstration Project (August 18, 1989 - May 31, 1990)." That section described the major "start-up" activities that were involved in getting the Demonstration to the point of being able to offer services on June 1, 1990. In the present section, two central questions will be addressed:

- (1) What are the *major activities* that were accomplished during the first thirteen months of service delivery of the Demonstration (i.e., June 1, 1990 - June 30, 1991), including the key resources expended and actions performed, and what was the *degree of congruence* between these activities and those originally planned?

- (2) What *factors facilitated* the implementation of the Demonstration during this first year of service delivery, and what *barriers interfered* with project operations during this period?

### **Sources of information**

This section, as the last, is based primarily on two sources of information: semi-structured interviews with key State, Womack Army Community Hospital, and Rumbaugh staff, and relevant documents. During the spring and summer of 1990, a series of interviews was held with 39 individuals representing North Carolina's MH/DD/SAS, members of the Project Oversight Committee from Womack Army Community Hospital (WACH), and Rumbaugh staff members at the executive, section head, and service delivery levels. These interviews focused on eliciting information about the types and levels of activities that occurred during the first year of service delivery, resources available for the implementation of the Demonstration during that period, perceptions and expectations for the Demonstration and its individual components, and factors that either facilitated or impeded the implementation of the Demonstration during that period. Information from field office reports and site visits prepared by Evaluation Project staff was also incorporated.

Documents generated by or about the Demonstration were also reviewed, which included: all quarterly reports submitted to the Army by MH/DD/SAS; minutes of meetings such as those of the Project Oversight Committee; organizational charts and staffing reports of Rumbaugh; correspondence between MH/DD/SAS, Rumbaugh, and the Army HSC; policies and procedures developed by Rumbaugh staff; and correspondence and reports from groups and individuals with which the Demonstration has had contact.

### **Overall approach guiding this section**

Designed as part of an ongoing series of sections describing the implementation of the Demonstration, this section on the first thirteen months of service delivery continues to use Leginski et al.'s (1989) categories of basic managerial decisions and activities for mental health services. The categories continue to form the framework for discussing the resources and tasks involved during the time period. Five major areas described include: *acquiring resources* for the Demonstration; *distributing resources* within the organization; *monitoring* the organization's use of these resources; *accounting* for these resources; and *assessing* the impact of the organization, the compliance with plans and priorities, and the influence of factors on the implementation of the program.

### **Structure of the section**

This section is organized into three sub-sections. The first section summarizes the major activities of the Demonstration from June 1, 1990 to June 30, 1991 (the first thirteen months of service delivery). In general, it will provide an abbreviated description of the Demonstration's major activities using Leginski et al.'s (1989) categories of management decisions.

The second sub-section will describe in more detail the operation of each component of the Demonstration during this time period. Staffing patterns, dates of initiation of service-delivery for each component, and congruence with implementation plans will be reviewed. In the final section,

factors are discussed that either facilitated implementation of the Demonstration or imposed barriers to its successful operation.<sup>a</sup>

### **Major Activities of the Demonstration During the First Thirteen Months of Service Delivery**

The composite picture of the Demonstration's activities during its first thirteen months of service delivery and implementing a continuum of care on June 1, 1990 can be organized around five types of managerial decisions/actions (Leginski et al., 1989):

- (1) *Acquiring the necessary resources for the Demonstration.* This includes those actions aimed at procuring needed resources, including financing, staff, facilities, and even clients. Examples are hiring staff, contracting with local providers to deliver services, developing referral sources, and making arrangements with various third-party payers for services.
- (2) *Distributing resources.* These types of decisions and activities center on the allocation of resources among the various units/groups involved. Typical efforts include preparing budgets, negotiating unanticipated requests that involve financial implications, and deciding on specific contractual arrangements (e.g., establishment of reimbursement rates for external providers).
- (3) *Monitoring how resources are utilized.* Decisions and duties required for overseeing resource consumption within the Demonstration cover several different domains. These include, to name a few, the development of formal reporting requirements, review of reports, and the installation of a management information system that can generate and monitor "key indicators" of effort and resources expended by the organization.
- (4) *Accounting of resources.* This category of activities involves those tasks and decisions that demonstrate control over resource utilization. In addition to financial accounting practices, accountability efforts frequently entail the formulation of policies about staff performance and clinical treatment.
- (5) *Assessment of resources.* As previously described, these activities focus on determining whether organizational inputs and outputs are appropriate. Assessments are of two types. Compliance assessments involve making judgments about whether things actually occurred or were supposed to happen as a result of certain organizational actions (e.g., an increase in the hiring of minorities as a result of new agency guidelines or improvements in services delivery subsequent to changes in the allocation of program resources). Impact assessments are directed at determining whether particular expenditures of an organization's resources produced the desired outcome(s) e.g., enhanced levels of client functioning as the result of treatment).

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<sup>a</sup> For an overview of the Ft. Bragg Demonstration Project, refer to the previous chapter section of the Implementation Study, "Developing a Continuum of Care for Children's Mental Health Services: The First Nine Months of the Ft. Bragg Demonstration Project, August 18, 1989 - May 31, 1990."

Figure 2-6 presents a detailed enumeration of the major actions taken by the Demonstration, including those carried out by MH/DD/SAS and Rumbaugh.<sup>9</sup>

Briefly stated, the majority of activities during the thirteen-month period were directed at acquiring resources, distributing them among participants, and developing monitoring and accounting procedures for tracking how these resources were allocated and expended. The major efforts under each of these more general categories are briefly described following Figure 2-6.

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<sup>9</sup> The activities that occurred under the auspices of the Evaluation Project are not detailed in this report, given that this document is part of the overall evaluation effort at Vanderbilt University.

**Figure 2-6**  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Acquisition of Resources**

- ◆ finalized details of contracts with Lee-Harnett MH/DD/SA Area Program
- ◆ continued to prepare for and obtain necessary licensure and certification for program elements
  - obtained necessary insurance for opening of residential and day treatment programs
- ◆ continued to recruit, hire and train staff
  - full time clinical staff grew from 40 (approved 6/1/90) to 154 (hired by 6/30/91)
  - administrative staff grew from 5 (approved 6/1/90) to 11 (hired by 6/30/91)
  - continued to maintain a computerized database for job applicants
- ◆ continued to purchase necessary capital equipment and supplies
- ◆ continued to locate and rent facilities for offices, day treatment, group homes
- ◆ continued to expand and upfit facility
- ◆ secured leasing of vehicles (5 sedans and 4 vans)
  - to transport clients in the residential and day treatment programs and as a "last resort" to transport clients in the outpatient program
  - also used for client visits by staff in the in-home and case management sections
- ◆ screened referrals before scheduling intake assessments
  - established a telephone screening process in order to lessen intake load

**Figure 2-6 (continued)**  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Acquisition of Resources (continued)**

- ◆ admitted clients for services
  - performed 2,312 intakes during the first 13 months
  - increased case load from 120 expected as of June 1, 1990 to 1,386 active clients and 89 pending assessment as of June 30, 1991
  - provided services to a total of 2,470 clients
- ◆ developed and distributed beneficiary handbooks
- ◆ continued contracting with private psychologists, psychiatrists, social workers, other mental health professionals, and hospitals
  - by 9/30/90, signed contracts with 28 private providers, 10 corporate groups (including 59 providers), 4 MH/DD/SA area programs and 5 hospitals
  - set up system for credential review and privileging contract providers
- ◆ opened services in all components
- ◆ Assisted the chief health care provider for military families (PRIMUS) in modifying their contract to allow direct referrals to Rumbaugh Mental Health Clinic
- ◆ developed procedures for prescription medication to be made available
- ◆ renegotiated contract with Army to modify client eligibility
  - to include emancipated minors who are CHAMPUS eligible spouses and under 18
  - to include a portion of the payment for services to Willie M. clients
- ◆ renegotiated FY90 and FY91 budgets to reflect increase in client load
- ◆ prepared budget for FY92 to include increase in predicted client load

**Figure 2-6 (continued)**

**Major Actions Taken By the Fort Bragg Demonstration Project:  
June 1, 1990 - June 30, 1991**

**Distribution of Resources**

- ◆ renegotiated rate schedule for contract providers
- ◆ renegotiated Army contract for case management to include use of outpatient care coordinators
- ◆ provided ongoing training opportunities for staff
- ◆ conducted intake staffings on all new clients to determine appropriate initial level of care
- ◆ conducted treatment meetings on a regular basis to design and coordinate client care
- ◆ participated in meetings to coordinate care to Rumbaugh clients
  - schools at Fort Bragg, in Fayetteville, and the surrounding area
  - Womack Army Community Hospital
  - other community agencies
- ◆ provided intake materials to contract providers and ongoing case monitoring
- ◆ provided client transportation when necessary
- ◆ determined priorities for client care in the face of greater than expected number of clients
- ◆ established system of communicating organizational, policy and procedure changes to all staff members
- ◆ received technical assistance from MH/DD/SAS on multiple issues, including meeting licensure and certification requirements, developing justification for additional vehicles, reviewing the physical facility, developing DEERS procedure to use prior to installation of DEERS terminal, assisting with cost projections
- ◆ decreased utilization rate based on total number of clients served in inpatient hospitalization and residential treatment centers
  - June 1990, 7% of caseload
  - June 1991, 1.6 % of caseload

**Figure 2-6 (continued)**

**Major Actions Taken By the Fort Bragg Demonstration Project:  
June 1, 1990 - June 30, 1991**

**Monitoring Utilization of Resources**

- ◆ continued meeting of the Project Oversight Committee on a monthly basis
- ◆ continued preparation of quarterly and other reports to document and relay information about project activities to the Army
- ◆ developed surveillance procedures for MH/DD/SA to monitor performance of Rumbaugh and Vanderbilt
- ◆ initiated use of computerized data base for generating customized reports for various users
- ◆ developed Quality Assurance/Utilization Review system
  - reformulated Quality Assurance system into an ongoing Quality Improvement process
- ◆ reviewed and revised policies for subcontracting to private providers
- ◆ established regular committee meetings for clinical management, review of credentials, clinical records, UR, QI, provider advisory, and other issues
- ◆ prepared audit plans
- ◆ continued to develop and refine policies and procedures related to Rumbaugh operations
- ◆ continued to monitor and attempt to reduce length of waiting list for intakes
- ◆ continued monitoring of compliance with personnel requirements
- ◆ participated in surveillance activities
  - NC MH/DD/SAS
  - Army Office of the Surgeon General
  - Army Health Services Command
  - WACH COR

***Figure 2-6 (continued)***  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Accounting of Resources**

- ◆ provided ongoing supervision to staff at all levels
- ◆ reviewed treatment planning and documents submitted by contract providers
- ◆ initiated billing system for clients with additional insurance benefits
- ◆ initiated reimbursement system for contract providers
  - set up system for clinical case managers to authorize hospital stays
- ◆ reported on Willie M. and clinical cost outlier expenses on a monthly basis
- ◆ documented DEERS eligibility of potential clients through established procedure
  - DEERS terminal installed in June, 1991
- ◆ documented all clinical services through extensive clinical records procedures
  - transcription services provided for clinical notes and reports
  - clinical records reviewed regularly
- ◆ participated in independent audits
  - FY90 closeout audit of Cardinal by Ray Clinebelle, C.P.A.
  - 3/27/91 audit by the Defense Contract Audit Agency
- ◆ initiated and gathered information on numerous QI studies across the program components
- ◆ established system for keeping minutes at all official committee meetings

**Figure 2-6 (continued)**  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Accounting of Resources (continued)**

- ◆ participated in surveillance and monitoring visits
  - 10/17/90 Mrs. Price of OTSG, LTC Dohanos, Mr. Swan, and Mrs. Mathis of HSC received administrative update of the project
  - 11/28/90 COL Fagan and Mrs. Price OTSG and LTC Plewes of Walter Reed Army Medical Center visited to review active cases, clients' records, and to get an overview
  - 3/91 Dr. Roy Haberkern, child psychiatrist, under contract to MH/DD/SAS, initiated peer reviews to monitor client management at Rumbaugh
  - 3/25-26/91 administrative and clinical review by HSC COL Brenz, LTC Dohanos, CPT Stockmeyer, Mrs. Mathis, LTC Plewes (Walter Reed), MAJ Batzer and CPT Morris (WACH)
  - 4/24/91 LTC Dohanos and Mrs. Mathis conducted a review of the administrative programs
  - 4/15/91 surveillance visit by CPT Morris
- ◆ notified Army that approved budget amount was not adequate
  - requested relief for the State for costs that exceeded the approved contract
  - submitted revised FY 91 budgets reflecting increase in clinical services associated with increased client load

***Figure 2-6 (continued)***  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Assessment of Resources**

- ◆ received feedback from surveillance and monitoring visits and addressed recommendations
  - FY90 closeout audit of Cardinal by Ray Clinebelle, C.P.A., indicated positive opinion of compliance and fiscal responsibility in all areas with the exception of budget compliance organization's allowable costs exceeded the approved budget and had not received a budget modification as of his report date (by \$629,135)
  - 11/28/90 visit by COL Fagan raised concerns regarding adequate personnel and a completed QA plan
  - 3/25-26/91 CPT Stockmeyer noted minor deficiencies in QA program, COL Brenz noted that there were a few discrepancies in clients charts but, in general, the evaluations were thorough and superb
  - 4/15/91 surveillance visit by CPT Morris
    - letter response by Dr. Behar 5/2/91
  - 4/24/91 Assistant Secretary of the Army provided the 1st quarter FY91 Report on the Fort Bragg Child and Adolescent Mental Health Demonstration Project to the Chairman, Committee on Appropriations, United States Senate
    - Dr. Behar responded by letter on 6/12/91, clarifying "misperceptions"
  - 6/4/91, MH/DD/SAS received a copy of the "Analysis of CHAMPUS Per Capita Mental Health Expenditures and Utilization for Beneficiaries Less than Eighteen Years," prepared by the U.S. Army Health Care Studies and Clinical Investigation Activity
    - Dr. Behar responded 6/12/91, asking that the report be retracted as it was "premature, inaccurate, and biased"

**Figure 2-6 (continued)**  
**Major Actions Taken By the Fort Bragg Demonstration Project:**  
**June 1, 1990 - June 30, 1991**

**Assessment of Resources (continued)**

- ◆ continued review of contract provider competencies and revoked privileges when determined that criteria violated
- ◆ restructured several organizational elements due to initial experiences
  - reorganized staff roles and responsibilities in CETS, residential care, and case management in response to program experiences and client needs
  - developed an acute care group home in response to large hospital case load
  - restructured organization of business section
- ◆ initiated support groups for staff and clients in response to Desert Shield and Desert Storm
- ◆ expanded number of staff in all sections in response to increase in client load
- ◆ continued assessment of the adequacy of the approved budget to meet the client load demand
- ◆ increased concern about costs of the project were voiced by Project Oversight Committee members and HSC staff
- ◆ worked on estimating predicted future costs of service in order to prepare budget for following fiscal year

### **Acquisition of resources**

Although by June 1, 1990, the "start-up" phase of the project was completed, the next thirteen months continued to involve an intense amount of effort directed to acquiring needed resources. This effort was a result of an immediate surge of requests for services that far exceeded planning. Directly related to this issue were increases in the client load, the budget, and the staffing plans, and contracting with private providers.

**Increase in the client load.** Originally, Rumbaugh had been told to expect approximately 160 clients to present for service during the beginning of this service period. In fact, by the end of the first month, more than 200 transition cases<sup>10</sup> and an additional 366 potential clients had received or been scheduled for an intake assessment. This level of request for service continued for the entire first thirteen month period: by September 30, 1990, 725 cases were open and 196 more were pending intake assessment or first appointment; by December 31, 1990, there were 1166 active cases; by March 31, 1991, 1,352 active cases were open with an additional 167 pending assessment or first appointment. By the end of the thirteen month period, the client load was appearing to stabilize at approximately 1,500. During this time 2,312 intake assessments had been performed and services had been provided to a total of 2,470 clients.

The increase in client load resulted in a steady increase in (a) the number of clinical staff members needed to provide services; (b) the number of administrative staff needed to support the clinical program; and therefore, (c) the budget for the Demonstration.

**Budget increases.** The originally predicted budget designed to serve a client load that slowly increased from 120 to 425 over this same thirteen month period, was for a total of \$5,011,096<sup>11</sup>. By June 30, 1991, however, the Army had been notified multiple times that the MH/DD/SAS was reaching the budget maximum for the entire fiscal year (both for FY90 and FY91) and that budget revisions were necessary to be able to continue to provide services to the number of children and adolescents presenting for service. By June 31, 1990, MH/DD/SAS had requested an increase to \$14,227,738. However, by that time the budget figure approved by the Army HSC was \$12,000,000, and MH/DD/SAS had already notified HSC that amount was expected to last only through August 15, 1991 (when the fiscal year end was September 30).

**Increased staffing patterns.** The staffing patterns at the Rumbaugh similarly underwent significant expansion. Within the thirteen month period, the number of full-time clinic staff positions increased from 35 to 137. Original staffing plans, based on estimates of client need by HSC, had progressed in the sequence indicated in Table 2-2 below:

By June 30, 1990, after only one month of service delivery and a client load and waiting list in excess of 500, Rumbaugh immediately shifted to "Plan D", and by September, 1990, was already talking about a "Plan E" that exceeded any previously planned client load and related

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<sup>10</sup>"Transition" cases are those who were already receiving mental health services under the CHAMPUS program prior to June 1, 1990.

<sup>11</sup>These budget figures reflect the FY91 fiscal year that represents October 1, 1990 - September 30, 1991, and thus, does not correspond exactly with this 13-month period. These figures highlight, however, the issues involved in budgetary needs during this time period.

**Table 2-2**  
**Cardinal Staffing Plan**

<u>Plan/ Date</u>	<u>Predicted Client Load</u>	<u>Actual Client Load</u>	<u>Planned Number Clinic Staff</u>	<u>Actual Number Clinic Staff</u>
A/8/1989 - 5/1990	160-200	566 <sup>a</sup>	35	35
B/6/1990 - 9/1990	240-300	921	50	92 <sup>c</sup>
C/10/1990- 9/1991	320-400	1475 <sup>b</sup>	60	137 <sup>d</sup>
D/10/1991- 5/1994	400-500	NA	69	NA

**Notes:**

- a. As of 6/30/90, after the first month of service delivery, 200 transition cases had been opened and an additional 366 potential clients had received or had been scheduled for an intake assessment.
- b. This number represents the active cases on 6/30/91 (POC Meeting Minutes, 7/17/91).
- c. This number represents the number of clinical staff employed or scheduled to begin employment on 9/30/90 (POC Meeting Minutes, 10/17/90).
- d. This number represents the clinical staff positions filled on 6/30/91. There were a total number of 154 positions authorized at that time (POC Meeting Minutes, 7/17/91).

number of clinical staff. The recruitment, hiring and training process for quadrupling the number of clinical staff during the first year took a significant amount of effort on the part of every level and section of staff at Rumbaugh. A computerized data base was quickly expanded as was national advertising and recruitment for positions. The development of a generous fringe benefit program took on even more importance in the light of the need to recruit over 100 additional clinical staff members to a program with a limited life span<sup>12</sup>. These recruitment efforts were successful in their ultimate achievement of most hiring goals. However, certain positions remained understaffed at the end of the thirteen month period. Qualified substance abuse counselors proved especially difficult to attract to the Fayetteville area.

Contracting with community providers. Along with the hiring of additional Rumbaugh staff, the Demonstration quickly finalized contracting arrangements with community psychologists, social workers and psychiatrists to whom clients could be referred when outpatient services appeared to be the only service needed. By the end of the thirteen month period, a total of 148 contract providers had signed contracts and were either temporarily or fully privileged. Finalizing the contracting process took longer than expected, and it was not until several months after the doors opened that contracts were secured with private providers, corporate groups of providers, several MH/DD/SA area programs, and several inpatient hospitals in the Fayetteville and Raleigh/Durham/Chapel Hill area. In addition, a credential review/ privileging process meeting

<sup>12</sup> The Demonstration Project contract calls for an end date of May 31, 1994.

JCAHO standards was begun in order to ensure appropriate licensure or certification, competence, and relevant experience before contract providers were allowed to provide care to Rumbaugh clients. As of June 30, 1991, this process had still not been completed with the contracted providers and continued into the next period of operation.

Arranging for clinical services was another major focus during this initial period of service delivery. On June 1, 1990, the basic clinical components as specified by the contract and budgeting negotiation were in place: (1) Intake assessment and emergency services; (2) treatment services including Outpatient, and In-Home Services provided through Rumbaugh and inpatient hospitalization and residential treatment through contract; and (3) Case Management. By September, school consultation was available and contracts had been signed with 10 therapeutic family homes whose members were undergoing training. By the end of December, the first group home operated by Rumbaugh was opened as was the Afterschool Program through Community Education Treatment Services (CETS). Within three more months (March, 1991), two more group homes had opened and the Day Treatment Program of CETS was operational. The service components will be described in more detail below.

#### **Distribution of resources**

As new resources were added to those already in place, decisions regarding how they would be allocated to the various administrative and clinical components of the Demonstration were continually made. This involved not only receiving and distributing funds, but also prioritizing client care and coordinating services and resources.

Intake staffings, treatment team meetings, and case coordination. For each of the 2,470 clients served during the thirteen month period, a variety of mechanisms for assuring appropriate and coordinated care were implemented. Multidisciplinary intake staffings were planned to be held within 2 working days of the intake assessment, at which time the initial level of care was determined and referral made to the appropriate provider or section. For the majority of cases, this involved referral to a community contracted provider for outpatient care. When it was determined that a child was in need of more than outpatient care alone, a clinical case manager was assigned, and the appropriate components within Rumbaugh activated. [For a discussion of the myriad issues involved in case management, see below.] Treatment team meetings were held at times specified by the contract, with teams for hospitalized clients meeting at least every 3 weeks and for clients receiving other more-than-outpatient care every 30 to 45 days. For any changes in level of care, prior review at a treatment team meeting was required. Case coordination took place at these meetings, in section staffings, during contact among staff members, and with involved community providers and agencies. Staff across all clinical sections reported a high percentage of their time devoted to such coordinating activities.

Prioritizing resources. With the client load increasing rapidly and remaining during the entire period at levels higher than staffing patterns reflected, ongoing tension regarding the prioritization of resource distribution was evident. Early on, a decision was made to utilize community contract providers to the greatest extent possible to absorb the large numbers of outpatient-only clients. This allowed the Rumbaugh clinical staff to devote as much time as was possible to the development of the more-than-outpatient service options. Even within Rumbaugh, however, pressure was continually felt regarding the high number of clients in need of services. Intake Assessment and Case Management were the two components that, by contract, could not

maintain a waiting list for services but were required to respond to each client in need of services. Continual monitoring of the intake waiting list increased the tension on that component to develop a screening process and utilize contract providers to conduct intakes. Other components developed internal waiting lists for services that could be offered once staff were recruited, hired, and trained.

In addition, several reorganization efforts were realized in response to initial experiences.

Changes in clinical case management. With the surge in number of clients admitted, the clinical case management process quickly came under scrutiny. By contract, case management was to be provided to all clients<sup>13</sup> at a staff to client ratio not to exceed 1:20. However, the original intent by the Demonstration planners was for this contract provision to apply only to those clients receiving more-than-outpatient, residential or inpatient care, which would have been a subset of the client population. Army interpretation of the contract, however, was that all clients were to receive this case management. With a case management staff hired in anticipation of 200-300 clients but a caseload quickly approaching 1000 by the sixth month of operation, actual case manager caseloads exceeded 100. The primary focus became securing the required documentation of services received and review at appropriate intervals. This section was initially restructured to provide supervision for an increasing number of staff, and later proposed a contract revision that would create new positions entitled Outpatient Care Coordinator (OCC). These OCCs would be responsible for managing the care of outpatient-only clients with a caseload of up to 80, and clinical case managers could assume their previously designated function of providing case coordination to clients at the more intensive levels of care. A more detailed description of the case management section is given below.

Development of an acute care group home. The high number of clients utilizing inpatient hospitalization, the most restrictive and expensive of the services in the continuum of care, prompted exploration of alternatives for serving this population. Clinical staff determined that a number of these clients could benefit from a less restrictive, short-term program that would help stabilize acute psychiatric episodes. An acute care group home with specialized staffing was developed, cost justification based on reducing use of hospital beds was submitted to the Army, and this service became available in February, 1991. A more detailed description of the Residential Services component is given below.

### **Monitoring utilization and accounting of resources**

Continued development of monitoring plans and carrying out of accounting functions also constituted a significant focus during the initial thirteen month period of service delivery. The monitoring activities centered on establishing procedures for overseeing resource consumption at the Demonstration, while the accounting functions followed by documenting the actual performance in the specified areas.

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<sup>13</sup> The only exception were those clients receiving services only from the Outpatient Services section of Rumbaugh Clinic.

Establishment of surveillance procedures. Several levels of surveillance procedures and activities were developed and implemented during this period. MH/DD/SAS, as contractor, instituted a formal surveillance plan for both Cardinal, Inc. and Vanderbilt University. This procedure was submitted to and approved by HSC as part of contract specifications. In addition, the COR at WACH developed and initiated a surveillance plan on behalf of HSC. Members of HSC and the Army Office of the Surgeon General also conducted sporadic surveillance visits regarding various aspects of contract compliance. These surveillance activities were conducted in addition to other monitoring held for the purposes of issuing licenses, certificates, or accreditation by the North Carolina Dept. of Human Resources.

Development of the Quality Assurance system. The Medical Services section at Rumbaugh was given responsibility for establishing and monitoring a system-wide procedure for assuring quality of clinical services. JCAHO specifies procedures to be followed and areas to be addressed, and by contract, Rumbaugh is to meet the JCAHO standards for quality assurance. During this period, examination of the QA process and staff changes resulted in reformulation of the QA system into an ongoing Quality Improvement and Risk Management (QI/RM) system. Activities of the QI/RM system are described in the quarterly reports to the Army prepared by MH/DD/SAS. This area continued to be one that received ongoing monitoring and feedback through the various surveillance mechanisms described above.

Participation in audits. Two independent audits were conducted at Rumbaugh during this period. The State of North Carolina requires a single, comprehensive audit at the end of each fiscal year. The FY90 closeout was conducted by Mr. Ray Clinebelle, C.P.A., who indicated a positive opinion of contract compliance and fiscal responsibility in all areas except that of budget compliance. As discussed earlier, with the increased client load, expenditures accelerated at a faster pace than approved revisions to the budget. At the end of FY90, after four months of service delivery, Rumbaugh's allowable costs exceeded the approved budget by \$629,135 and budget modification had not been received by the date of Mr. Clinebelle's report. The appropriate budget revision was received later, however. In late March, 1991, the Defense Contract Audit Agency conducted a similar review but no report was issued.

Implementing the service documentation, billing, and reimbursement system. The implementation of a system for documenting services delivered to clients, billing other payers, and reimbursing contract providers involved financial, management information system, clinical support, and clinical staff members. Event ticket codes used by clinicians (and equivalent service documentation by contract providers) were entered into the MIS, generating both service description and billing information. Clinical case managers (CCMs) played an intermediary role for clients in inpatient hospitals and residential treatment centers, contracted services. For these two levels of care, an authorization-of-services procedure was developed by which CCMs reviewed and authorized specific services and periods of time for a particular client's care. After each authorization, including re-authorization in the case of clients who remained in these settings for an extended time, the billing office at Rumbaugh handled reimbursement requests sent by the contract providers. The development of software available to process this information took longer than anticipated, and it was not until February, 1991, that service data began to be entered into the MIS. Shortly thereafter, customized MIS reports began to be generated for various users. However, these data, especially those for services, were not considered reliable until October, 1991. Internal problems with the completing and posting of event tickets resulted in an underestimate of services delivered within Rumbaugh.

### **Assessment of resources**

The activities associated with assessment of Demonstration resources took two primary forms: (a) evaluating the level of resources needed to provide services to the eligible clients who presented for care; and (b) assessing the compliance of the Demonstration with requirements imposed by the contract and by the community best-practices doctrine for professional services. The concern with budgetary resources and the actions taken to secure additional funds have been discussed above. The forms of feedback from formal surveillance and other sources and impact on the Demonstration follow:

**Army oversight of the Demonstration.** Two formal surveillance visits, one on November 28, 1990 by COL Fagan (OTSG), and one on March 25-26, 1991, by COL Brenz and CPT Stockmeyer (HSC), resulted in feedback about various aspects of the clinical program. COL Fagan outlined concerns about case management services (client to staff ratio), treatment team activities, and clinical records documentation. In his follow-up visit, COL Brenz's review regarding appropriateness of clinical services and status of clinical documentation reported Rumbaugh activities to be "thorough and generally superb." The QA system, however, received "deficient" marks from both COL Fagan and CPT Stockmeyer. Concerns were raised about: (a) the incompleteness of the procedures for credentials review and privileging; (b) lack of evidence of putting the proposed QA/QI system into motion; and (c) utilization management, described by Stockmeyer as "disjointed." Based on this feedback, Rumbaugh implemented activities at various levels to enhance the QI system. However, at the end of this thirteen month period, these issues had still not been resolved and the Army continued to monitor the areas of concern.

**Other Army feedback about the Demonstration.** Two other Army documents surfaced during the first year of Demonstration service delivery that (a) highlighted Army concerns about the costs of the Demonstration, and (b) resulted in closer oversight of project operations. In March, the Army OTSG submitted a report to the Senate and House Committees on Appropriations about the Demonstration, based on information from the MH/DD/SAS quarterly report and COL Fagan's visit. His concerns, outlined above, were repeated as well as cost concerns using CHAMPUS data as a comparison.

In April, 1991, the Army Health Care Studies and Clinical Investigation Activity (USAHCSCIA) released an "Analysis of CHAMPUS Per Capita Expenditures and Utilization for Beneficiaries Less than Eighteen Years." Based on CHAMPUS data from the pre-demonstration period, it was reported that the three catchment areas involved in the Evaluation Project (Fort Bragg, Fort Campbell, and Fort Stewart) showed no trend in increase in utilization, thus arguing that trends in increasing utilization should not be used as justification for the increased client load at the Demonstration.

In response to both of these negative reports, MH/DD/SAS provided arguments and information about the use of CHAMPUS data, comparisons between the Demonstration and standard CHAMPUS service delivery, and communication problems that needed clarification. The USAHCSCIA report was described as "premature and technically flawed." Further surveillance by the Army was the direct outcome of these evaluations.

## **The Continuum of Care and Its Components**

The preceding sub-section described the major activities conducted across all sections of Rumbaugh during the thirteen month period following initiation of service delivery on June 1, 1990. The actual clinical services provided in the continuum of care comprised several components: (a) intake assessment and emergency services; (b) case management for clients receiving more-than-outpatient or inpatient services; and (c) treatment provided by Rumbaugh and contract providers, including: outpatient, day treatment and afterschool, in-home counseling, residential, inpatient, psychiatric and substance abuse services. Section 1 of this chapter describes the "preparedness" of these service components on June 1, 1990, as the "doors were opened" for service delivery at Rumbaugh Mental Health Clinic. The continued development of the treatment components throughout the thirteen months that followed are described below.

**Intake Assessment and Emergency Services.** On June 1, 1990, the Intake Assessment and Emergency Services Section was generally equipped to begin its clinical efforts. The Section Head and number of staff specified by Hiring Plan A were hired, trained, and in place, based on an expected demand for intake assessments at the rate of 20-30 per week. Contracts for the crisis line screening and emergency services were in place. A standardized intake protocol was developed that included child and parent clinical interviews, developmental history, social and family history, behavioral checklists from multiple informants, and substance abuse screening for youth aged eleven years and older. The contract required a response to service requests within a one week period. Emergency assessments were planned to be available on a 24-hour-per-day basis within two hours of request.

Immediately, however, the Intake staff were inundated with requests for intakes for new referrals coming into the system. By the end of the first month, 366 new clients had requested services and had either participated in an intake assessment or were scheduled for one. The number of staff in this section quickly grew from three to eight, with the number of intake assessments scheduled averaging from three to eighteen per day over the next thirteen month period. By December 31, 1990, the section had received 1,244 new referrals and performed 1,167 intake assessments. By the end of the thirteen month period, 2,631 new referrals had been received and 2,312 intake assessments performed. With these numbers, scheduling was difficult, and the waiting list remained in the three to four week time frame until November. In January, again, the referral rate climbed and the waiting list remained a constant target for reduction. Several options were explored, including the use of private contract providers to perform intakes. Required packets of written information were also mailed to families ahead of time in order to accelerate the necessary process of documentation. The telephone screening process, in place since June 1, 1990, in order to screen out ineligible children and adolescents from the intake assessment process, continued.

In examining patterns of referral to Rumbaugh, WACH was designated by over 25% of the clients during the first thirteen months as their primary source of referral. Individual or family referrals accounted for another 25%, with mental health professionals designated as the primary referral source for 19% of the population and the schools for an additional 16%. The remaining referrals came from other health facilities, social services, juvenile court, and other sources.

**Outpatient Services.** Outpatient services were provided through two mechanisms: (a) by community contract providers (about 90% of the cases) when outpatient services alone appeared to meet the child or adolescent's needs; and (b) by Rumbaugh staff members of the Outpatient section for children and youth with more serious problems who require a wider range of intensity and frequency of services. Rumbaugh Outpatient staff were able to see clients up to five times per week during periods of crisis, as well as provide treatment in concert with other services provided at Rumbaugh. As with Intake/Assessment, the Outpatient section was staffed and ready to provide treatment as of June 1, 1990, according to Hiring Plan A. In addition, approximately 20 contracts with community providers were awaiting signature.

Although the increase in service demand hit all sections at Rumbaugh as soon as the doors opened in June, 1990, the Outpatient section within Rumbaugh was less directly influenced. Clinicians were able to accept appropriate new cases until their case loads were full, but they were then relieved from having to accept new referrals through the use of a waiting list. The number of staff in this section did increase over the course of thirteen months, with eleven full-time clinical staff in addition to the Section Head by June 30, 1991. By that time, 228 children and adolescents had been admitted to the in-house Outpatient section, with an active caseload of 142.

The availability of community contract providers addressed most of the needs of the surge in referrals, as the presenting problems appeared to be those of a less intense nature and appropriate for outpatient therapy. This capacity increased significantly, with contracts signed with 148 community providers by the end of the thirteen month period. By June 30, 1991, these contract providers were responsible for 1,613 active and aftercare clients.

**In-home Services.** In-home services at Rumbaugh were modeled on "family preservation" programs and designed to prevent out-of-home placement of children and adolescents in families experiencing acute crisis. In addition, this service was developed as a less restrictive alternative to which children could be transitioned following inpatient hospitalization or residential treatment. When Rumbaugh opened its doors on June 1, 1990, In-home was the only alternative service between outpatient and residential treatment care that was fully operational. Under Hiring Plan A, however, this involved the Section Head and one other employee, who took extended leave in June. The goal was to assign caseloads of two to four families per therapist, who are available 24-hours-per-day. By the end of the thirteen month period, this section had grown to a total of eight staff members, three of whom had been recently added in June, 1991, with three additional positions in recruitment. Of 123 referrals to this section over the thirteen month period, 65 had been served with an average length of stay of eight weeks<sup>14</sup>.

**Community Education and Treatment Services (CETS).** CETS provided two levels of day treatment services to children and adolescents with serious school maladjustment. Day Treatment services met daily beginning in March, 1991, during school hours for clients whose problems were so severe that an out-of-school placement was required. Afterschool services met five afternoons per week for 3 hours per day beginning in late December, 1990, for clients who were able to

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<sup>14</sup> Length of stay figures contained in this report are calculated on the basis of cases that have been discharged. These data were presented by Rumbaugh at the July 17, 1991, P.O.C. meeting.

remain in school and the community with intensive support. Both services were designed both to prevent the use of more restrictive, out-of-home placements and as step-down services from an inpatient hospital stay.

When Rumbaugh first began providing services in June, 1990, however, CETS was not operational. At that point, school consultation was available through a staff psychologist, but the Section Head was not brought on board full-time until October, 1990. In December, 1990, the Afterschool program opened. In early March, 1991, the Day Treatment program opened and quickly filled to capacity. One of the tasks of this section was to reach the criteria for becoming certified as a "nonpublic school" in order to provide such services in the State of North Carolina. As the initial thirteen month period ended, this section had grown from a staff of two to twenty-seven with plans to open a second day treatment program within a few months.

Residential Services. This component was originally intended to be gradually phased- in during FY91, thus on June 1, 1990, only three staff members were employed, program development was underway, but no facilities had been procured. The timeline for providing residential services was accelerated in an attempt to divert the use of inpatient hospital beds that was associated with the surge of clients admitted. By June 30, 1991, the number of staff in this section had grown to fifty.

Two programs constituted the Residential Services section: Therapeutic group homes and therapeutic family homes. A third initiative, family support services, was in the planning stages at the end of the thirteen month period in response to client needs expressed, but had not yet been implemented.

Therapeutic group homes were designed to provide an intensive, highly structured treatment program in a more natural setting than the more restrictive options of residential treatment center or inpatient hospital. Opening of the group homes was delayed, in part, due to difficulty securing appropriate rental property. First, community reaction to planned group homes was problematic. In addition, rental facilities had to be located that would comply with State licensure requirements. In late December, 1990, the first group home opened with a capacity client load of six. Two additional group homes opened in February, 1991, one of which was designated as an "acute" care home with a staff to client ratio of 1:2 in order to serve clients in acute psychiatric distress. By the end of June, 1991, these three group homes had received 65 referrals and admitted 30 clients. The average length of stay at that time was 11 weeks.

Therapeutic family homes were originally called "treatment foster care" but the name was changed in response to feedback from client parents. Although therapeutic home services were available to Demonstration clients through a contract with another community agency beginning June 1, Rumbaugh operated homes began serving families in October, 1990. These homes provided highly flexible and individualized services to children and adolescents who could not be maintained in their own family's home. By December, contracts with 10 therapeutic families had been recruited and training had been provided, and by March, 1991, an additional 3 therapeutic families were on board. These families were paid by Rumbaugh as contractors instead of staff members, thus requiring payment only when a client was actually placed in their homes. In addition, some families agreed to accept a second client on a planned, occasional basis as a respite service for Rumbaugh client families. This program was able to respond quickly due to the

presence of an ongoing treatment foster care program operated by the MH/DD/SA area authority that helped with both recruitment and training of therapeutic families. By June 30, 1991, the therapeutic family homes had received 89 referrals, admitted 16 clients, with an average length of stay of 9 weeks.

**Inpatient Services.** Within the continuum of care implemented by Rumbaugh, inpatient hospitalization and residential treatment center services were provided exclusively by contract providers. Contracts were maintained with several child and adolescent inpatient psychiatric programs in the area, which were selected based on the special needs of the client or family preference. This service continued to be used more heavily than expected when the absolute number of placements and resulting costs is examined. When the mean number of acute hospital beds per day are added to those in the residential treatment center, the total mean in June, 1990, and June, 1991, was very similar, 20.0 and 23.83, respectively. The number of acute hospital beds/day increased over the period while the use of the residential treatment center dropped. With the tremendous increase in client load, however, the percentage of clients receiving services in this setting dropped dramatically from 7% of total case load in June, 1990, to 1.6% of total case load in June, 1991. The financial pressure exerted by this utilization provided the impetus for development of alternate levels of care prior to the scheduled dates and the justification for budget increases to meet the reimbursement requests.

**Psychiatric Services.** Psychiatric services were provided across all levels of care by either Rumbaugh staff psychiatrists or contract providers. The role of psychiatry included direct services (psychiatric evaluations, medication, therapy), treatment team participation, and Quality Improvement functions regarding hospital treatment. By the end of the thirteen month period, two full time child psychiatrists were on staff with Rumbaugh and contracts were maintained with an additional 40 community psychiatrists. The Rumbaugh staff psychiatrists had accepted referrals for 372 psychiatric evaluations by June 30, 1991.

**Substance Abuse Services.** Substance abuse services were also provided across all levels of care by Rumbaugh staff members located either within the sections or within the Medical Services section. Substance abuse screenings were built into the intake assessment process for all clients aged eleven years or older. Comprehensive substance abuse evaluations were completed on 64 clients by June 30, 1991. In addition, specialized substance abuse work was delivered through individual and group work throughout the various Rumbaugh sections. Children and adolescents in need of specialized substance abuse residential treatment received services through a contracted residential treatment center or inpatient hospital.

**Case management.** Case management services were staffed at the anticipated Hiring Plan A level and ready to receive cases when the doors opened on June 1, 1990. As mentioned above, the surge in number of clients admitted caused the clinical case management process to quickly come under great pressure. With a case management staff hired in anticipation of 200-300 clients yet a caseload quickly approaching 1000 by the sixth month of operation, actual case manager caseloads exceeded 100 and the primary focus was on securing the required documentation. Cases had to be prioritized, with services received first by clients who were at the highest risk for out-of-home placement. Case managers were responsible for scheduling and facilitating treatment team meetings, writing and updating treatment plans, and assuring that the appropriate referrals were made and treatment provided.

This section was initially restructured to provide supervision for an increasing staff, and later new positions were created entitled Outpatient Care Coordinator (OCC). These OCCs were responsible for managing the care of outpatient-only clients with a caseload of up to 80, and clinical case managers assumed their previously designated function of providing case coordination to clients at the more intensive levels of care with the caseload goal of less than 20. It was not until this restructuring that clinical case managers, in general, had time to perform the myriad of linkage functions with families, schools, community providers and others that had been originally intended. By June 30, 1991, this section had 25 full-time staff members with a caseload of 1,689 clients, of which 1,613 clients were being monitored with community outpatient contract providers.

### **Factors Facilitating or Impeding Implementation of Service Delivery**

Factors at the organizational, community, and contractual levels influenced the implementation of the Demonstration during the period from June 1, 1990 to June 30, 1991, the first thirteen months of service delivery. Factors that facilitated the implementation of the Demonstration are reviewed below, followed by a discussion of factors that interfered with implementation as planned.

A major factor that continued to enhance the implementation of the Demonstration after the start-up period and into the initiation of service delivery was the structure of Cardinal, Inc., as a private not-for-profit corporation. Cardinal was organized for the sole purpose of running the Demonstration and, thus, was able to focus all of its efforts to this endeavor. This ability would have been greatly compromised had the Demonstration, given its rapid growth, been nested within another organization with additional areas of responsibility competing for attention and resources. The not-for-profit status also allowed flexibility on a number of levels that would not have been as easily accomplished in a public sector organization. As in the start-up period, it continued to be necessary to attract qualified clinicians, and Cardinal was able to offer an attractive and flexible benefits package. The organization also was able administratively to shift resources quickly as needed from one area to another to meet changing demands.

The expectation of flexibility and developmental change was evident throughout the planning process and into the first year of service delivery. This expectation permeated all levels of the organization and resulted in an attitude, in general, of interest and challenge rather than frustration at the multiple changes that took place in policies and procedures, staffing, program development, and other areas. The June 1, 1990, to June 30, 1991, period continued to be a time of flux, growth, and reorganization far after the first nine month start-up period was past. Examples of the flexible use of resources included: use of contract providers to fill in the gaps when the number of clients started increasing so rapidly, both as therapists and as intake workers; staff from sections not yet formally operational coming to the aid of intake and case management staff who were overwhelmed early on with requests for service; and shifting resources among sections as roles and responsibilities were better defined.

staff, especially evident among the section heads who were selectively recruited and participated in many joint planning endeavors. Similarly, the executive team was viewed by those internally and externally as working as a cohesive unit that was very supportive of the staff and their needs. Again, the importance of the shared philosophy about treatment in a continuum of care provided not only an incentive for staff members to move from distant places to join the team but to persevere in the face of heavy caseloads and long hours during this initial phase of service delivery.

The coordination of services at the individual client level was also viewed by staff members as invaluable in implementing a continuum of care that truly individualized care. Formal treatment team meetings, section staffings, and meetings with community providers and schools all provided opportunities for information sharing and decision making. The treatment teams also carried the authority to procure the recommended service.

Resources available to the Demonstration continued to be evident past the start-up period and well into the service delivery period. The cost-reimbursement contract allowed the continued renegotiation by MH/DD/SAS of funds when justified by the increasing demand for services. The State of North Carolina provided funds for an operating advance, at the two million dollar level by this reporting period. Qualified and well paid staff, training resources, outside expert consultation, new facilities, and availability of needed supplies were all examples of the level of resources available. The MH/DD/SAS staff was available for dealing directly with HSC, providing oversight to keep the Demonstration on track, facilitating licensing and certification processes, and contributing other administrative support. Although the executive team in concert with MH/DD/SAS became increasingly sensitized to cost containment issues toward the end of this period, staff members at the section head level and below experienced access to needed resources for staff or clients during this time period.

Finally, two important buffers were present to allow those at Rumbaugh to focus on clinical service delivery issues and protect them from the growing consternation of the Army HSC at costs that exceeded original projections. Both the MH/DD/SAS and the WACH members of the Project Oversight Committee played this role. As the contractor, MH/DD/SAS negotiated with HSC for more funds. As the client load increased, MH/DD/SAS was supportive by negotiating almost constantly for more resources. As the Army responded with requests for justification, MH/DD/SAS served as the mechanism for obtaining needed information not only from Rumbaugh but from other national experts. Similarly, MH/DD/SAS acted as an advocate for the program by directly approaching Congress to appropriate additional funds for the Demonstration. In the same vein, the WACH members of the POC acted as both intermediary between the Army HSC and Rumbaugh and translator in many instances, helping each to understand the concerns and reality of the other. The initial group of POC members, including both WACH and Rumbaugh staff, had helped to develop the Demonstration project by their involvement during the past several years, participated in many joint problem solving activities, and appeared invested in seeing the Demonstration follow through with original plans.

Several key factors, however, also emerged as barriers to successful implementation of the Demonstration as planned. As has been evident throughout this chapter section, the high volume of clients presenting for service on June 1, 1990, and beyond continued to pose difficulties for the implementation of the Demonstration throughout the thirteen month period in a variety of ways.

The three- to four-fold demand for services over what was anticipated strained clinical services in every component, overwhelmed the staff members, overran the facilities, and tripled the expected cost of the project during this one year period. An extensive amount of time at the Rumbaugh, MH/DD/SAS and Army HSC levels was required to project revised costs, develop an updated budget, and negotiate for these revisions.

The reasons for the significant increase in client load over the number that predicted was the source of much discussion. Several factors emerged: (a) the initial figures furnished by OCHAMPUS, showing approximately 150 children in treatment in the Fort Bragg catchment area during early 1990, were incomplete, with the actual number presenting for transition services being almost 300; (b) the eligible population in the WACH catchment area had increased approximately 18.3% to 41,600 dependents under age 18 from the initial estimate of 36,000 made in early 1989; (c) the opening of a new service in an area formerly lacking in the range of services provided the opportunity for those previously in need but unable to access services to suddenly present for services; and (d) the elimination by HSC of the annual deductible and co-payment requirement appeared to lessen the barriers to accessing care. Desert Storm and Desert Shield deployment was heavy from Fort Bragg and appeared to result in serious psychological effects on parents and guardians who were overwhelmed with the fear of losing their significant other, and this parental stress increased the instability in the children. Although Desert Storm was initially believed to cause additional increase in the client load, the service request pattern subsequent to this time period has shown similar high level of requests, so no direct Desert Storm effect has been demonstrated. However, deployment of the pediatric, family practice, and psychiatric staff from WACH did appear to increase referrals to Rumbaugh that may have previously been handled at WACH.

The increased numbers of clinically diagnosable children who presented for services appeared primarily to be those for whom the less intensive services were recommended. Of the total 2,470 clients served during the June 1, 1990, to June 30, 1991, period, 1,613 (65%) were being followed by contract providers for outpatient-only services and an additional 228 (9%) had been served by the Rumbaugh Outpatient Services program. The review mechanisms that had been planned originally for a caseload of predominantly seriously emotionally disturbed children became burdensome when applied to this population. Contract negotiation with the Army was required in order to relieve Rumbaugh of frequent reviews of this population and reformulate case management for this population to be conducted by Outpatient Care Coordinators, allowing a caseload of up to 80 outpatient-only clients.

The quick expansion of services in addition to the difficulty in initiating alternative services that were not part of the mental health "mainstream" such as day treatment, residential services, and case management, posed a related impediment to successful implementation of the Demonstration as planned. Although specified in the contract as providing a full continuum of care for the population, Rumbaugh had developed a plan for staggering the services into operation based on the budget negotiation process with the Army. Need for intermediary services between outpatient and inpatient care, however, was felt immediately and in great numbers. The "planful" implementation of these components was, instead, forced to rush ahead. Recruitment, hiring, and training of staff was involved in large scale. In the interim, the Intake Assessment and Case Management sections were overwhelmed. These two components could not develop waiting lists until staff members and service slots became available, but instead continually had to serve clients.

Frustration developed between the sections, especially at the level of staff members with clinical caseloads, and communication problems were reported during this time of significant expansion and change.

Probably exacerbated by the increase in client numbers but inherent in the continuum concept were problems regarding role ambiguity, continuity of care, and family involvement. With children and adolescents involved in multiple levels of care, different staff members with different roles all interacted with the child and/or family on a regular basis. Clinical responsibilities became blurred at times, and keeping all those involved informed was a task delegated to the already overwhelmed clinical case managers. When clients changed from one level of care to another, for instance from a group home to Outpatient Services, the primary therapist switched because staff operated within sections organizationally. Communications with family members could and did take place by staff members from several sections as well as case managers; some families reported confusion and frustration over the complexity of the system and concern that they were being overwhelmed with requests to be involved in multiple activities each week. Treatment team meetings offered the opportunity to deal with these issues on an individual case basis, while section heads met together to smooth out operations at the system level. These types of problems, however, are endemic with a system as complex as the Demonstration. Although formal documentation does not suggest these problems were anticipated, they were recognized and procedures (e.g., section quality improvement studies) were initiated to address them, in part.

Finally, the relationship between the Army and the Demonstration appeared to become more and more strained over the course of this thirteen month period. Although rising costs remained at the center of the discussions, increasing surveillance activities resulted in demands that would likely increase costs further. Relatively unfamiliar with contracting for services such as those provided by the Demonstration, the Army required documentation and monitoring to an extent greater than that of usual clinical practice. Although concerns about the clinical record system appeared to be worked out by June 30, 1991, difficulties implementing the quality assurance program as specified by the Army continued to be a problem. MH/DD/SAS was put in the position of challenging reports generated about the Demonstration by the Army Office of the Surgeon General and USAHCSCIA. The POC, set up to play an intermediary role, was not given any additional time or resources devoted to that role. The members from WACH had conflicts with other job duties to which responsibility for the Demonstration had been added. As this time period closed, the WACH members of the POC were reconstituted as a result of job moves. New members were awaiting POC orientation as June, 1991, closed.

The issues raised during this first period of service delivery of the Fort Bragg Child and Adolescent Mental Health Demonstration will continue to play out as the second year of service delivery unfolds and will be described in subsequent sections.

## Section 2 Documents and Other Background Materials

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**APPENDIX C**

**STATEMENT OF WORK**

{ Not in record  
didn't happen }

C.1.1. SCOPE OF WORK. The Fort Bragg Mental Health Demonstration is an innovative approach for providing quality mental health services to children and adolescents. [REDACTED] through this contract, [REDACTED] will provide a Federal and State program of providing a total integrated care system for all Fort Bragg military youth services utilizing a multi-agency effort. This demonstration will cover beneficiaries residing within a 40 mile radius of Fort Bragg called the catchment area -- identified by zip codes. Attachment 1 hereto is the zip code listing for the Fort Bragg catchment area. The purpose of this contract is to ensure that this benefit of service will result in improved treatment outcomes with the cost of care per client is decreased when compared to current levels of costs.

9 - how measured?

pull case records  
claims records  
... check zip codes  
... age groups

• The problems  
back to OA  
Plan why don't  
you have this

- Absence of family history
- Occasional
- Paraphimosis
- Absence of pain with family

length of steel  
How often was the patient  
institutionalized

Privat

AP-1000-  
Sullivan, Rose

Adult  
written  
oral

Child  
must have  
passed  
adult

C.1.3.1. **Physicians:** A physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who has completed residency requirements and is board eligible in his/her field, and licensed to practice in the state of North Carolina.

C.1.3.2. **Psychiatrist:** A psychiatrist shall be a physician who has completed residency requirements and is board eligible or board certified in Psychiatry and shall be licensed to practice in the state of North Carolina.

C.1.3.3. **Child Psychiatrist:** A child psychiatrist shall be a physician board eligible or board certified in Child Psychiatry and shall be licensed to practice in the state of North Carolina.

C.1.3.4. **Child Psychologist:** This specialist shall meet the requirements in North Carolina for a Practicing Psychologist and have the credentialing requirements recommended by the American Psychological Association. These practitioners shall have specialized case work in child development, psychopathology, and developmental disabilities, psychotherapy techniques with children, and psychological assessment techniques with children, youth and families; experiential training in treatment and assessment of children and families from different racial backgrounds and social-economics status in a variety of clinical settings; specialized research contributing to an understanding of children families and psychological development.

C.1.3.5. **Practicing Psychologist:** This specialist shall have graduated from an accredited clinical psychology doctoral training program, have completed ... two post-doctoral years of supervised diagnostic and treatment experience, and have passed the qualifying examination of the North Carolina State Board of ... Examiners of Practicing Psychologists.

C.1.3.6. **Examining Psychologist:** This specialist shall possess a master's degree in an accredited psychology training program, be licensed, and function under the supervision of a Practicing Psychologist.

C.1.3.7. **Clinical Social Worker:** This professional shall meet the State requirement for Social Work Clinical Specialist which includes having a thorough knowledge of social work principles, techniques, and practices, and their application to complex casework, group work and community problems; thorough knowledge of a wide range of behaviors and psychological problems and their treatment; thorough knowledge of family and group dynamics and a wide range of intervention techniques; considerable knowledge of the methods and principles of casework supervision and training and the ability to supervise, train, or instruct lower-level social workers, students, or interns in the program. The minimum training and experience requirements are a master's degree from an accredited school of social work and three years of

fully qualified per  
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social work or counseling experience; or a master's degree in a counseling field and four years of social work or counseling experience.

**C.1.3.8. Nurse Clinician (for child/adolescent services):** This specialist shall meet the State licensure/certification requirements which include having a thorough knowledge of nursing theories, techniques, and practices in child/adolescent mental health; considerable knowledge of psychiatric nursing, nursing practice and administration, and behavioral concepts and treatments in child/adolescent mental health. Ability to make thorough detailed assessment of patient needs and develop appropriate solutions; ability to direct and supervise the work of others in the area of specialty. The minimum education and experience required is a master's degree which provides the knowledges, skills, and abilities needed to perform work in the area of child/adolescent mental health and one year of experience in this area; or graduation from a State accredited school of professional nursing and three years of experience including two years in the area of child/adolescent mental health; or an equivalent combination of education and experience. The individual shall be licensed to practice as a Registered Nurse in North Carolina.

**C.1.3.9. Substance Abuse Counselors, Special Educators, Teacher-Counselors and other Day Treatment Staff:** These professionals shall meet the State licensure/certification requirements for employment. These requirements include a four year college degree plus a master's degree and 1 year of supervised experience in a mental health related field. ~~In addition, each requires specific training and certification in the specialty field - teaching or substance abuse counseling.~~ These providers shall function under weekly supervision by senior level clinicians.

**C.1.3.10. Other Individual Professional Providers.** The services of Marriage and Family Therapists Pastoral Counselors, and Mental Health Counselors shall be used only if the patient is referred by a physician for the treatment of a medically diagnosed disease or disorder, and the physician is involved in monitoring the patient's ongoing care. The marriage and family counselor, pastoral counselor or mental health counselor shall certify written communication has been made or will be made to the referring physician of the results of the treatment. Such communications shall be made at the end of the treatment or more frequently, if required by the referring physician. Mental health counselors, foster care parents, and others participating in this community based project as providers, caretakers and/or members of the contractor's alternative living treatment team and in other levels of care shall be trained and certified as required by the state of North Carolina and competent to participate in this project. The contractor shall ensure that procedures or regulations used to accomplish licensing and training requirements for these individuals conform with current state statutes. These alternative providers shall be under physician supervision.

through document -  
ask for list of  
supervisors

What is  
supervision  
of this

7

Needs to be done  
weekly & less

How many times  
with family  
unit  
at least 2  
family no  
documented  
State Social  
Services  
Amendment 0001

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C-3

- Best friend checks  
- Anyone living in household  
- Don't forget to check

How many times  
is a unit of child & family

C.1.3.11. For the purposes of this contract, CHAMPUS-authorized institutional providers, provider groups (accredited by the Joint Commission on Accreditation of Healthcare Organizations, as appropriate) and individual providers include those who are certified or licensed by the State of North Carolina and contracted to provide services under this demonstration. The contractor shall provide resumes and staff qualifications for key project personnel and a detailed staffing plan (Numbers of various staff positions, descriptions (by position) of duties, responsibilities, supervision and supervisor responsibilities, charts, ect.) along with his proposal.

C.1.3.12. CONTRACTOR PERSONNEL. All persons performing under this contract shall remain personnel of the contractor or subcontractor and not personnel of the Government.

C.1.3.13. CONTRACTOR'S REPRESENTATIVE. Within 10 calendar days after contract award, the contractor shall provide in writing, the name and local phone number of an individual to act as his representative who will be responsible for overall coordination and implementation of services to the contracting officer and COR.

C.1.3.14. CONDUCT ON THE INSTALLATION. The contractor's personnel will not be permitted on the installation if their presence is considered detrimental to the security of the installation. The Government reserves the right to require removal from the job site of any contract personnel who endangers persons or property, whose continued employment is inconsistent with the interest of military security or who is found to be incapacitated or under the influence of alcohol, drugs or other substances. Removal of personnel for cause does not relieve the contractor of the requirement to perform services specified herein.

#### C.1.4. CONCEPT OF OPERATIONS

C.1.4.1. The proposed demonstration shall have three distinct organizational components:

C.1.4.1.1. Overall responsibility for project management which shall be maintained in DMH/MR/SAS State Office, including planning, project funding, data management, monitoring, and quality assurance.

C.1.4.1.2. An independent evaluation component shall be established through a contract between Vanderbilt University and the state of North Carolina.

C.1.4.1.3. A direct service component shall be established through a subcontract with the Area Program Authority. DMH/MR/SAS has a relationship defined by State statute with the Area Program, which is an entity of local

**C.1.4.2. Entry into the System:** Children/adolescents shall enter the service system in accordance with state and federal requirements.

C.1.4.3. The services provided shall be based upon a thorough diagnostic study leading to an individualized treatment plan for each child. The process of entry into the system is critical, requiring the highest level of professional skill to determine whether or not services are actually needed and, if so, what specific services are needed.

**C.1.4.4. For non-urgent and non-emergency care, diagnostic services shall begin within a 2-3 days period following the request or prescript for services.**

**C.1.4.6.** For non-urgent and non-emergency care, diagnostic services shall begin within a 2-3 day period following the request or prescript for services.

Services to child and family shall continue on a regular basis, as an interim measure, while the diagnostic study is completed, reviewed by the Treatment Team, presented to the family and to others significant in the child's ecological system, and implemented. (The diagnostic study shall begin within the week of referral and shall be completed and reviewed by the Treatment Team in two weeks, or less.) The treatment plan will be reviewed and modified, if necessary, by the Treatment Team. The treatment plan will be implemented immediately; the full treatment plan will be completed within 72 hours of initial contact, unless a more complex assessment is needed at the most within two weeks following completion of the plan. Thus, the process from referral to full implementation of the treatment plan might take an average of two weeks. During this time period, the child and family shall receive regular services as clinically determined or at intervals consistent with the patient's physical and mental health status. For treatment plans that take longer to implement, it is important to recognize that not only might the diagnostic process be complex, but community based treatment may require considerable planning and negotiation with professionals in other systems to obtain relevant information and to establish acceptance of the treatment plan and willingness to assist with implementation. Documentation of explanations for increased time shall be made.

6.1.4.5. Emergency and urgent services shall be available on a 24-hour basis. Sites for the provision of emergency services shall be located at Fort Bragg, all the Area Programs (8) in the Fort Bragg catchment area and at other sites to be determined by need. A 24-hour telephone service shall provide crisis counseling and direction to the nearest emergency site. Transportation shall be provided as defined in the approved transportation plan. Assessment shall be provided within two hours of the request, and immediate treatment shall be provided, if needed. When the child/adolescent can be stabilized, diagnostic services shall begin within 24 hours; during and upon completion of the diagnostic assessment, treatment services will be provided immediately, as an interim measure, until the full treatment plan is implemented as described above. To assure that a thorough diagnostic assessment is made, the

what are statistical Fed  
requirements

\* see Qualifications  
HOT!

See Intake docume

Has a Dr. decided  
See list of stuff doing

14.

— 222 —

Lee chart

How are you implementing this

7 sit at site  
make up an emergency  
letter to intake  
site + hand  
it to us

Should not be  
a temporary  
contract man  
(6) suits  
See schedule

**DADA10-89-R-0018      Amendment 0001**

**C-3**

diagnostic process and resulting treatment plan, both of which are automated, shall be used allowing for monitoring for completeness. The final format for the diagnostic process shall be submitted to the Administrative Contracting Officer for approval within 120 days after contract award.

Swan #7  
see this delinable

C.1.4.6. The treatment system shall be based on the assessed treatment needs of each client. A central characteristic of the system may be best defined as the capacity to "wrap" individualized services around each client, rather than fit the client into an existing set of program components. The system created around each child's clinical needs must be dynamic allowing for change resulting from treatment impact and other factors such as developmental changes or changes related to the school year. Criteria to be used as guidance in determining levels of care shall be developed and provided to the Administrative Contracting Officer for approval within 150 calendar days after contract award.

Look at criteria  
Delinable #1  
Criteria level should be  
charted.

C.1.4.7. Intake/assessment: A thorough diagnostic assessment shall be completed for each client. Highly trained professionals shall evaluate the treatment needs of each client. Through the case manager, input will be obtained from others significant to the individual client, such as his/her teacher, court counselor, and/or protective services worker and provided to the diagnostician. Even though these professionals do not provide medical or psychological services, their role in the child's life is significant; therefore their observations of the child, their goals for the child, and interactions with the child and family must be considered. A coordinated approach is important to the success of treatment. The professionals participating in the assessment shall meet with the Treatment Team and together design the treatment plan. The Treatment Team shall be composed of a child psychiatrist, a doctoral level practicing child psychologist, and the supervisors of service components, who are fully qualified mental health professionals. Either the child psychiatrist or child psychologist will head the Treatment Team but both shall participate in the review of treatment plans.

Did this happen?  
How long did it take?

Treatment team must  
Sis<sup>Phn</sup> MD + Ph4

C.1.4.8. Non-emergency referrals will receive services within one week, during which time background data shall begin to be collected. It is essential to proper diagnosis that historical data and indices of current functioning be obtained from schools, physicians, courts, family, and others involved with the client. For emergency situations and walk-ins, services will be provided within two hours or sooner, if needed. Face to face emergency services shall be available on a 24-hour basis.

chart review

C.1.4.9. At the emergency facility, initial assessments, brief history, and statement of presenting problem will be completed immediately, by a senior level clinician. Emergency services, crisis stabilization shall be provided immediately, if required. Back-up emergency services shall be available, as

\* check record & see if  
shd criteria on  
level of care needed

needed. The determination shall be made as to whether emergency treatment shall be provided at the site, whether an in-home worker shall accompany the family home or whether an admission to a hospital, or other setting is warranted.

C.1.4.10. Following stabilization, the diagnostic study will proceed immediately if indicated or within the week if the emergency nature of the situation is resolved. The diagnostic study will address all five Axes of DSM-III-R. Every child/adolescent shall receive an assessment which shall include a clinical interview of the child and parent(s); a review of educational, social, psychological, intellectual, and interpersonal functioning; developmental history; physical assessment relevant to perceived mental health problems; assessment of stresses, and level of reaction to them; a global assessment of functioning; formulation of a clinical diagnosis; a statement of treatment goals; an individualized treatment plan. These studies shall be completed under the supervision of the Medical Director of the demonstration by senior level clinicians. A physician shall complete the Axis III diagnosis. Other disciplines will participate, as required. (Diagnostic studies shall be reviewed by the Treatment Team.)

## C.2. DEFINITIONS/ABBREVIATIONS/ACRONYMS

**Beneficiary** - A person who is the dependent of an active duty service member or retiree and retirees as defined by DCD instruction 6010.8-R who are authorized medical benefits in a military treatment facility or from civilian sources as government expense.

**Capital Equipment** - Non expendable items of equipment having a value of \$100 or more for non-medical items, medical equipment with a value of \$200 or more and furniture with a value of \$300 or more.

**Case Manager** - An individual responsible for coordinating and monitoring treatment provided.

**CHAMPUS** - Civilian Health and Medical Program of the Uniformed Services. This is a benefits program authorized by Congress to provide medical and psychological services necessary to authorized beneficiaries.

**CHAMPUS Claims** - A specified format for the billing and payment for medical services payable by the CHAMPUS and billed on a CHAMPUS Form 900, NCHA Form 1500 or US 82.

**Collateral Visits** - Sessions with the patient's family or significant others for the purpose of information gathering or implementing treatment goals.

**Component** - portion of the managed care system where services are

Non-physicians  
do not do Axis III  
diagnosis

Med director  
Samples per work

Physical conditions  
refer to psc and  
(probably not happening)  
Only a physician

Axis III  
diagnosis  
intention

\$500.  
HSC 11r 12 Nov 92  
per item

2520

provided (i.e. group home, out-patient treatment).

Contractor - State of North Carolina, Department of Human Resources

DEERS - Defense Eligibility Enrollment System. A computerized system which maintains current eligibility status for all health benefits beneficiaries.

DRG - Diagnostic Related Group. A system for grouping patients by the severity of their illness, diagnosis, complications, age, etc.

Fiscal Intermediary(FI) - An organization under contract with OCHAMPUS to process civilian medical claims under the CHAMPUS.

Ft Bragg Catchment Area - A geographic area around Fort Bragg which is defined by those zip code boundaries located in an approximate 40 mile radius of Womack Army Community Hospital.

Government - U.S. Government

Managed Care - A process whereby a third party directs patient access to and utilization of health care.

Parent - Refers to the biological parent, legal guardian or legally appointed foster parent who is responsible for the child's welfare and safety.

Provider(s) - Individual(s) licensed or certified to provide medical and psychological treatment.

Quality Assurance - Those actions taken by the Government to check services to determine that they meet the requirements of the Statement of Work and requirements of the Joint Commission on Accreditation of Healthcare Organization, U.S. Army Health Services Command, and individual hospital's medical staff quality assurance and risk management programs.

Sponsor - An active duty member or retiree, or deceased active duty member or retiree of a uniformed service.

Treatment Team - A multidisciplinary healthcare team which develops and monitors patient progress in a plan of treatment which is specific for that patient's diagnosis and treatment needs.

WACH - Womack Army Community Hospital

HSC - Health Services Command

DA - Department of the Army

DD - Department of Defense

CDR - Contracting Officer's Representative

SOW - Statement of Work

PFTN - Program for the Handicapped

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

MTF - Medical Treatment Facility

QC - Quality Control

FY - Fiscal Year

DEA - Drug Enforcement Agency

### C.3. GOVERNMENT FURNISHED FACILITIES AND SERVICES.

C.3.1. FACILITIES. During the hours of performance under this contract the contractor, contractor's personnel or the subcontractor shall have the use of designated space made available at Fort Bragg for performing intake, initial assessments or treatment as needed.

Get rid of this

C.3.2. SERVICES. The government shall furnish and install at government expense a DEERS terminal in the contractor's primary facility. This will be accomplished within 12 months of contract award.

### C.4. CONTRACTOR FURNISHED PROPERTY.

C.4.1. When occupying government furnished facilities, the contractor shall provide all desks, tables, telephones, etc necessary to function properly.

C.4.2. The contractor shall provide name tags for his employees working on the government installation.

C.4.3. The contractor shall insure that each physician providing medical services under this contract has a rubber stamp containing his/her name, degree, and DEA license number. This stamp will be placed on all forms and documentation having the physician's signature.

Example: John J. Jones, MD  
DEA #

## C.5. SPECIFIC TASKS/SERVICES.

C.5.1. The following patient care services shall be provided and paid for by the contractor under this contract. (Services C.5.1.1. through C.5.1.10 are currently CHAMPUS authorized services).

C.5.1.1. Outpatient or inpatient services in CHAMPUS authorized general or psychiatric hospitals, Residential Treatment Centers, or specialized treatment facilities.

C.5.1.2. Professional services rendered in the diagnosis or treatment of a covered mental disorder by qualified providers including psychiatrists, physicians, clinical psychologists, certified psychiatric nurse specialists or clinical social workers, marriage, family and pastoral counselors under physician supervision and other providers authorized in Chapter 6 of DOD directive 6010.8-R. — *No others*

C.5.1.3. Individual psychotherapy

C.5.1.4. Group psychotherapy

C.5.1.5. Family or conjoint psychotherapy

C.5.1.6. Psychological testing and assessment

C.5.1.7. Administration of psychotropic drugs

C.5.1.8. Collateral visits.

C.5.1.9. Medical evaluation and testing required to assess the patients' clinical status at the time of admission or intake.

C.5.1.10. Ancillary therapies such as art, music, dance, occupational shall be used when prescribed by the attending provider in an approved treatment plan.

C.5.1.11. Respite services.

C.5.1.12. Independent living which is restricted to adolescents over 16 years of age and must include family member involvement in all treatment provided.

C.5.1.13. Alternative family living arrangements: These services shall be provided in a licensed home with specially trained staff. Treatment of patients in this environment will include family involvement.

*County charges out of service*

*How much is this hypenix?*

*do we have m. 2-21-82*

*Childs record - Ask Ca. doing how much been affect*

Notia high school graduate

See (5<sup>1-2</sup>)  
pg (6-10)

These need to be checked.

C.5.1.15. Crisis stabilization of 7 or fewer days in a qualified (professionally supervised environment.) - ( ) what is this?

#### C.5.1.18. Day treatment

How are these being provided.

How all  
provided.  
see Pharmacy contract  
CARDINAL —

7-2-1944

C.5.1.23 added (see reverse of page)

By Pooos  
2/1/90



C.5.2.3. Services to certified members of the "Willie M." class are excluded under this contract, with the exception of those class members who reside on federal land and who are not included in C.5.2.5 and C.5.2.6.

C.5.2.4. Services provided to CHAMPUS beneficiaries who are enrolled in or are eligible for the CHAMPUS Program for the Handicapped (PPTH) shall be excluded from this contract.

C.5.2.5. Services to CHAMPUS beneficiaries with the following DSM-III-R diagnoses will be excluded unless accompanied by Axis I diagnosis or other non-excluded Axis II diagnosis: mental retardation, including mild, moderate, severe, profound and unspecified mental retardation, specific developmental disorders, including academic skills disorders, language and speech disorders and motor skills development.

C.5.2.6. Services that are the responsibility of school systems will not be covered by this contract. These include diagnostic assessment for academic placement, vocational planning, career guidance, placement in school programs or classes for exceptional students or any other placement service not related to diagnosis or treatment for mental health problems.

C.5.3. The contractor shall provide a centrally managed program which coordinates all care and treatment provided and/or prescribed for patients using the contractor's services system. *Contract provided and was accepted at time of award.*

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C.5.3.1. MANAGED CARE. The contractor shall provide case managers who shall be responsible for patient access to and utilization of the contractor's service system. ~~Each case manager shall be responsible for no more than 20 patients.~~ The case manager shall be responsible for insuring arrangements are made for patients to enter and/or move between the various levels of care and/or treatment settings. The case manager is responsible for monitoring the placement of the patient in a treatment setting as it relates to an approved treatment plan and for coordinating the activities of the treatment team. Case managers shall be individuals who are either: MD, RN, PhD Psychologists, or Special Education Teachers or other qualified mental health professionals and shall be supervised by the Clinical Director.

Notes  
use of  
case manager

Easy to monitor  
They are not doing  
deleted (see below)  
P00027  
2/4/92

C.5.3.2. TREATMENT TEAM. The Treatment Team shall be a multidisciplinary team composed of the supervisors of outpatient services, day treatment services, case management services and residential services; both a child psychiatrist and a child psychologist shall be on the Treatment Team, as well as other necessary professional and non-professional personnel as required. The treatment team shall be responsible for the final development and approval of a treatment plan. The requirements for a complete treatment plan are listed under the patient management requirement in this contract. ~~Case managers shall insure information is presented to Treatment Team at least every 30 days while the patient is under treatment.~~

check this

Every child needs  
Treatment Team  
+ case manager

They are not doing  
it.  
deleted  
2/4/92 P00027  
See P00027  
for new language.

C.5.4. PATIENT MANAGEMENT. The contractor shall provide a case management

Add: C.5.3.1. ... contractor's service system. Ratio of case managers to patients of 1:20 is applicable to patients requiring a complex array of services (Type II patients). Case managers or care coordinators are not needed for outpatient only services (Type I patients).

system and insure sufficient documentation in treatment records which shall clearly document the assessment, progress, and outcome of care provided to patients treated under this contract. Sample formats for initial patient data collection shall be furnished to the contracting officer within 90 calendar days after award. Patients shall be managed within the service system to the following minimal standards:

**C.5.4.1. Intake:**

*Look at these*

**C.5.4.1.1. Written policies and procedures governing the intake process shall insure that information is obtained on all patients admitted or referred; describes procedures for accepting referral from outside agencies and organizations; records are kept on all patients and referrals; statistical data is kept on the intake process; and procedures are included for alternative referrals when an applicant is found ineligible for admission.**

**C.5.4.1.2. Methods of intake shall be based on the services provided and needs of the patient.**

**C.5.4.1.3. Criteria for determining eligibility shall be clearly stated in writing.**

**C.5.4.1.4. Intake procedures shall include an initial assessment of the patient.**

**C.5.4.1.5. Acceptance of patients for treatment shall be based on intake procedure results.**

**C.5.4.1.6. The record shall contain the source of any referral.**

**C.5.4.1.7. The intake process shall insure the patient understands the nature and goals of the treatment program, hours during which services are available, treatment costs.**

**C.5.4.1.8. Organizations which house patients overnight are licensed and/or certified by the State of North Carolina.**

*where are we at  
on this*

**C.5.4.1.9. Sufficient information shall be obtained during the initial intake to develop a preliminary treatment plan.**

**C.5.4.2. Assessment:**

**C.5.4.2.1. Each patient shall have a complete assessment, including clinical consideration of the patient's needs and a written, comprehensive, individualized treatment plan that is based on the assessment of the patient's clinical needs.**

*Look at  
reimbursement  
plans  
are current  
all the time.*

C.5.4.2.2. For all programs there shall be documentation to verify that a decision concerning the need to perform a physical examination was made prior to the development and implementation of each patient's treatment plan.

NOT being done  
MAY 13

C.5.4.2.3. The organization shall have an assessment procedure for the early detection of mental health problems that are life threatening, are indicative of severe personality disorganization or deterioration, or may seriously effect the treatment or rehabilitation process.

C.5.4.2.4. An emotional and behavioral assessment of each patient shall be completed and entered in the patient record.

C.5.4.2.5. A social assessment of each patient shall be undertaken and documented in the patient record.

C.5.4.3. Treatment plans:

C.5.4.3.1. Overall development and implementation of the treatment plan shall be assigned to an appropriate member of the professional staff.

C.5.4.3.2. The treatment plan shall be developed as clinical information becomes available and as soon as possible after the patient's admission or acceptance into the contractor's service system.

★ C.5.4.3.3. Within 72 hours following admission/acceptance to any inpatient or residential treatment organization, or upon completion of the intake process or partial hospitalization or outpatient treatment, a designated member of the treatment team shall develop a treatment plan based on at least the assessment of the patient's presenting problems, physical health, emotional status and behavioral status.

People at  
Campbell  
or US (Cardinal)

C.5.4.3.4. The treatment plan shall reflect the patient's clinical needs and conditions.

C.5.4.3.5. The treatment plan shall specify the services necessary to meet the patient's needs.

C.5.4.3.6. The treatment plan shall include referrals for needed services that are not provided directly by the organization.

C.5.4.3.7. The treatment plan shall contain specific goals which the patient must achieve to attain, maintain and/or reestablish emotional and/or physical health.

C.5.4.3.8. The treatment plan shall contain specific objectives that relate

to the goals, stated in measurable terms and include expected achievement dates.

C.5.4.3.9. The treatment plan shall describe the services, activities and programs planned for the patient and specifies the staff member assigned to work with the patient.

C.5.4.3.10. <sup>\*</sup> The treatment plan shall specify the frequency of treatment procedures.

C.5.4.3.11 <sup>\*</sup> The treatment plan shall delineate the specific criteria to be met for the termination of treatment.

C.5.4.3.12 <sup>\*</sup> The treatment plan shall include specific plans for the involvement of the family or significant others in the patient's treatment.

C.5.4.4. Progress notes: Progress notes shall be made for each patient which document the implementation of the treatment plan, actual treatment provided to the patient, chronological documentation of the patient's clinical course, changes in each of the patient's conditions and descriptions of the patient's response to treatment and the outcome of treatment and the response of significant other to important intercurrent events.

*Get into subcontractor's see their progress notes*

*Hospitalization Get with Cumberland their's*

<sup>\*</sup> C.5.4.5. Discharge summary and after care. A discharge summary shall be entered into the patient's record within 15 days after discharge or release from care. The summary shall include the results of intake assessment and diagnosis, the final primary and secondary diagnoses, a summary of pertinent findings and a final assessment which traces the patient's progress toward goal and objective achievement and a statement of the patient's condition at the time of discharge. The records shall include a written aftercare plan for continuing treatment if needed, and recommendations for after treatment support to the patient.

*IS it there?*

#### C.5.5. QUALITY CONTROL(QC) AND QUALITY ASSURANCE(QA).

C.5.5.1. The contractor shall be responsible for the quality of all services provided. The contractor shall establish a quality control program which shall monitor and evaluate aspects of care which are provided by the contractor's service system. Monitoring activities shall be conducted systematically and shall identify, evaluate, and correct problems. At a minimum the quality control plan and activities shall meet the following criteria:

C.5.5.1.1. The program shall objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems.

C.5.5.1.2. The QC program will be applicable to the entire organization including subcontractors.

C.5.5.1.3. Professional and administrative staffs shall monitor and evaluate the quality and appropriateness of patient care and clinical performance, resolve problems and report information to the governing body and the COR.

C.5.5.1.4. The contractor shall have a written plan for the quality control program which describes the objective, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation and problem solving activities. Specific guidelines shall be developed for the documentation in the records, and clinical justification and evaluation for the use of special treatment procedures such as the use of constraints, restraints, seclusion and others. This plan (including criteria/standards/forums) shall be submitted to the contracting officer with the contractors proposal and approved prior to award.

C.5.5.1.5. The program shall meet the required characteristics listed in the Chapter 9, Consolidated Standards Manual, JCAMP, 1992.

Current edition

C.5.5.1.6 Government Quality Assurance: The Government will monitor the contractor's performance under this contract using quality assurance procedures based upon the Quality Control program established by the contractor and approved by the contracting officer. Additionally, the contractor's performance is subject to scheduled and unscheduled review by the Project Oversight Committee, Administrative Contracting Officer and the COR during the term of this contract.

C.5.5.1.7 The contractor shall develop and submit to the contracting officer a statement of work to be used to subcontract with a University consortium composed of Vanderbilt, and Brandeis Universities to conduct an independent evaluation to determine if the managed care system required by this contract is a cost effective alternative of acceptable patient care quality as compared with standard CHAMPUS. The independent evaluator shall structure their evaluation such that each component of the continuum of mental health services, as listed in paragraph C.5.1, and the managed care functions are examined to determine if the patient's clinical care outcomes and the costs for services are an effective alternative to benefits received under standard CHAMPUS. The evaluator shall conduct a cost analysis of the continuum of mental health services such that determinations of cost effectiveness can be made. The evaluation subcontract shall run a total of 48 continuous months, subject to exercise of options of the basic contract and further subject to the availability of funds. The final report and all data collected shall be delivered to the Contracting Officer not later than the 15th calendar day of the 49th month following definitization of this contract. This contract

\* They do not have a 10 point QA plan as per JCATHO model

\* Need written documentation of the QA program

10 pt JCATHO QA plan as well as internal operational criteria

Need their plan for monitoring Vanderbilt

Need a # of monitorable outcomes / occurrences  
\* Indicators / thresholds  
Should cost report / patient / pharmacy  
1/0-100  
each level of care

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Susan -

supports a demonstration project to test the feasibility of expansion of this program. The government will use this information furnished by the contractor to develop changes to the basic CHAMPUS benefit. The contractor shall ensure that other demonstration/test projects shall not impact program implementation or results to protect the integrity of the evaluation required herein. Generally accepted principles of basic research shall be used as well as the use of Forts Campbell and Stewart as control sites. The contractor shall submit the specifications and research methodology to be used to the Contracting Officer within 90 calendar days after award. *definition of contract.*

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C.5.5.1.8. The contractor shall participate with Womack Army Community Hospital (WACH) to develop a project oversight committee. This committee shall be composed of representatives from the WACH and contractor's organization and shall meet a minimum of once per month. Functions of this committee include, but are not limited to: review of utilization data resulting from patients treated/referred to the area programs, review of the contractor's documentation and medical record review. The committee may recommend changes or modifications to contractor operations to the contracting officer. The committee shall be included in any approvals or general procedure used by patients receiving services under this contract. The contractor shall develop policies and procedures to be used by the Project Oversight Committee within the parameters outlined in this contract and shall deliver these policies and procedures to the contracting officer for approval within 90 days of contract award. The committee shall consist of ~~seven~~ *nine* members. The chairperson shall be appointed by the commander, Womack Army Community Hospital. The other ~~two~~ members representing the government shall be the COR and a representative of Hq, Health Services Command. The contractor's representatives shall be the project manager, project site manager, clinical director and medical director.

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*Chief, Dept of Psychiatry; Chief, Dept of Social Work;*  
C.5.6. PAYMENT FOR SERVICES.

C.5.6.1. The contractor shall develop a unit cost reimbursement system to pay for clinical services not later than 36 months after contract award. The contractor shall waive the traditional CHAMPUS cost share/deductible and there shall be no increased cost to the government by the waiving of this deductible. The contractor's format for the existing cost reimbursement system to include service definitions and costs shall be submitted with the proposal to the contracting officer and approved prior to award.

C.5.6.2. Rates paid by the contractor for services shall be the lesser of the CHAMPUS prevailing rate (or equivalent), the community standard rate for services not normally a CHAMPUS benefit, or the contractor negotiated rate. The contractor shall furnish a rate schedule within 120 calendar days of contract award and every 6 months thereafter, or within 30 calendar days of the inclusion of additional providers in the contractor's service system.

*Contractor shall furnish rate schedule to contracting officer for approval.*

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Q.H.F.k. { 70 H.A. 3 diagnosis  
C.A. 2K 100% of 100% of 100%  
- Should be 100% }

(See Attachment 5)

C.5.6.3. **Nonmental Health Medical Services.** Nonmental health medical services (for example, surgery, radiology or laboratory services) not related to the mental health diagnosis rendered during the course of a mental health treatment, and for which a separate charge is made, will be separately billed by the provider on a CHAMPUS claims form for benefit and reimbursement determination by the CHAMPUS fiscal intermediary for the mid-Atlantic region. Nonmental health services include diagnostic services required to rule out medical basis for mental health diagnoses, except for that testing which is required by the contractor's quality assurance screens for differential diagnosis, which shall be paid for by the contractor. For Inpatient Services, if a beneficiary receives care for a medical diagnosis and a mental health diagnosis, and the medical diagnosis is primary and reimbursable under CHAMPUS, such claims shall be paid by the Fiscal Intermediary for the Mid-Atlantic Region. If the beneficiary receives care for a medical diagnosis and a mental health diagnosis and the medical diagnosis is either not the primary diagnosis or is not subject to reimbursement under CHAMPUS Diagnostic Related Groups (DRGs), except for alcohol abuse related DRGs which, once published in the Federal Register, will be paid for by the contractor at the lower of the CHAMPUS DRG rate or the contractor's published fee schedule, (to include services rendered in DRG exempt facilities), the Contractor shall be responsible for hospital room and board charges, based on the primary diagnosis. Within 5 working days of identification, the Contractor shall forward to the medical fiscal intermediary a copy of the claim, along with information on any reimbursements made for mental health services; the fiscal intermediary will adjudicate the claim for nonmental health care on the basis of the line items appropriate to the medical services provided, to include those rendered by hospital based physicians.

\* Bring to her attention

C.5.6.4. The contractor shall establish a system for certifying referrals of patients who must receive care outside the contractor's services system. This system shall include a method of identifying claims such that the FI for the Mid-Atlantic region can readily identify these claims. Patients who obtain care without proper referral shall be responsible for payment. Eligible beneficiaries who reside apart from their sponsor, and the sponsor or parent reside in the catchment area, shall not be eligible for services under this contract unless the beneficiary resides with the non-sponsor parent or is attending a residential school within the catchment area. Contractor shall provide procedure to the Project Officer.

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C.5.6.5. Nothing shall preclude CHAMPUS eligible patients who reside outside the Fort Bragg catchment area from obtaining medically and psychologically necessary treatment from providers located within the Fort Bragg catchment area. These patients shall not be eligible for services provided under this contract except for normal CHAMPUS benefits as listed in the DOD instruction 6010.8-R. Services which may be offered to non-catchment area residents by

the contractor shall be on a space available basis only. The contractor shall not process CHAMPUS claims for non-catchment area residents as part of this contract. Project funds shall be used to cover services to military children/adolescents only.

C.5.6.6. Coordination of Benefits. The contractor shall provide a system for coordination of benefits to ensure that the contractor is secondary payer for any service or supply for persons enrolled in any other insurance, medical service, or health plan (except Medicaid) to the extent that the service or supply is also a benefit under the other plan. The contractor shall ensure that fees are collected from other benefit plans, except Medicaid, to cover the cost of services before project funds are used. The contractor shall retain any payments received through coordination of benefits. Monthly billing to the government will be reduced by the amount received from the coordination of benefits. Contractor shall provide procedure to the Project Office.

C.5.6.6.1. Exclusions. Coordination of benefits shall not be accomplished in connection with Medicaid, coverage designed to supplement CHAMPUS benefits, entitlement to receive care from NTFs, entitlement to receive care from Veterans Administration Medical Care Facilities, or certain federal government programs, as prescribed by the Director, OCHAMPUS, which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution.

C.5.6.6.2. CHAMPUS and Medicare. In situations involving dependents of active duty service members eligible for Medicare, Medicare is always primary payor. Retirees, dependents of retirees and survivors entitled to Medicare, Part A, are ineligible for CHAMPUS.

C.5.6.6.3. Subrogation. There will be no subrogation rights accruing to either the Contractor or to the Government. Subrogation requires that a party is authorized or required by law to furnish or pay for medical treatment for a person who is injured under circumstances creating a tort liability in some third person to pay damages for that care, the authorized party has the right to recover from the third person the reasonable value of that care and treatment furnished or to be furnished. See CHAMPUS regulation, DOD 6010.8.R, Chapter 12, Paragraph E.1. Since this right does accrue to the United States Government the United States Government renounces this right in contracting for the mental health services delivered under this contract to the Contractor, who is not an agent of the Government. The contractor, lacking agency, cannot therefore exercise the right of the United States Government.

C.5.6.7. The contractor shall establish a system to verify eligibility of patients under the Defense Eligibility Enrollment System (DEERS). No payment shall be made to any provider unless the patient is eligible to receive

who pays 1st

Look at claim for other health insurance. If it is not Medicaid then other Insurance. They should be billed 1st.

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?

60 to  
bills  
check return  
what are  
they doing with  
missed  
app 20 patients?  
financially?

CHAMPUS benefits. Until such time as an interface is established by the DEERS program office, the contractor shall verify that each patient over 10 years old has a valid DD Form 1173, Privilege Card, and that the sponsor or parent of patients under 10 years old have a valid military identification card or DD Form 1173, Privilege Card. The contractor shall verify through DEERS by coordination with U.S. Mawick Army Hospital, Fort Bragg, the eligibility of patients prior to services being provided. (The government shall not be responsible for payment of services for non-CHAMPUS eligible patients.) *Contractor shall provide evidence to the Project Office.*

*How is this being verified?*

*cy Pooas  
2/1/90*

#### C.5.7. APPEALS AND GRIEVANCES.

C.5.7.1. Chapter 10 Compliance. The contractor shall comply with the requirements for appeals under Ch 10 of the CHAMPUS Regulation DOD 6010.8-R(32 CFR 199.10). The contractor shall provide to the contracting officer a plan for implementing appeals/grievance procedures.

C.5.7.2. The contractor shall develop and submit to the contracting officer procedures to be used for appeals and grievances by patients using or referred to the contractor's service system. This procedure shall be communicated to prospective patients and be included in the contractor's marketing plan. The procedure shall define appealable issues as those arising from an adverse initial determination by the contractor for benefits provided under this contract. Appealable issues shall not include a challenge of the propriety, equity or legality of any provision of law or regulation, and the following:

1. Denial of issuance of a nonavailability statement;
2. denial of preauthorizations to obtain care; and
3. denial of authorization to seek care outside the catchment area.

The procedure shall insure that there is an initial notification made to the patient and that the patient's appeal rights and procedures are defined in this notification. The patient shall have at least 90 days to request in writing, reconsideration of the initial determination. The contractor shall have no more than 60 days in which to finalize a reconsideration and inform the patient of the decision in writing. The contractor shall have final action on disputes not exceeding amounts of \$50. Disputes of amounts over \$50 shall be further appealed to WACH. Final action shall be made on amounts in dispute of over \$50 and less than \$300. Appeals beyond this level shall be through HQ, US Army Health Services Command. Guidance regarding the development of an appeals system may be obtained from DOD Instruction 6010.8-R.

*- Something wrong? Have we had any complaints.*

C.5.7.3. Grievances are items which cannot be appealed. The contractor shall develop a procedure such that grievances be addressed and solved by the contractor. Should the patient not be satisfied with the action taken by the contractor, they may further addressed in writing to the project advisory committee for final resolution.

C.5.7.4. Procedures, policy and implementation for appeals and grievances

shall be submitted to the contracting officer not later than 150 calendar days after contract award.

C.5.7.5. Administrative appeals. The nature of a case management system necessitates that the mental health care will generally be reviewed either prospectively or concurrently and preauthorized or preauthorization denied. In cases of denial, it shall be necessary for the contractor to have an administrative system to review such denials. An administrative appeal system for such denials is mandatory under the contract. The contractor shall have sufficient appeal mechanisms for preauthorization decisions to ensure that the CHAMPUS benefit is not abrogated. Under Ch 10 for there to be an appealable issue there must be a disputed question of fact which, if resolved in favor of the appealing party, would result in the authorization of CHAMPUS benefits.

C.5.7.5.1. If preauthorization is denied by the contractor and the beneficiary does not obtain care, it would not result in the authorization of benefits because the medical necessity for mental health care would depend on the patient's current medical needs and not the patient's past condition.

C.5.7.6. The contractor's appeal system shall distinguish between mandatory Ch 10 appeals and administrative appeals required under subsections C.5.7.1. and C.5.7.2. above. The appeal system shall distinguish between the rules applicable to contracted (or employees of the contractor) and noncontracted providers where such distinction is applicable.

C.5.7.7. For this section the contractor shall act as a CHAMPUS FI. The Contracting Officer will perform the functions for a level of appeal beyond the contractor. If the Contracting Officer reverses the decision to deny payment made by the contractor, the contractor shall then pay for care received by the beneficiary. In the case where a provider is appealing the contractor payment decision, the Contracting Officer's reversal of the contractor's decision shall result in the contractor complying with the appeal request.

#### C.5.8. TRANSITIONS.

C.5.8.1. The contractor shall submit to the Contracting Officer a detailed plan for the operation of the managed care function with the proposal.

C.5.8.2. The plan for hiring and training of staff for the managed care function shall be submitted no later than ninety (90) calendar days after contract award. *Contractor shall submit plan to the contracting officer for approval.*

C.5.8.3. The provider/beneficiary community shall be advised of the procedures for accessing the managed care function beginning no later than sixty (60) calendar days prior to the start-work date.

*Chg Pass  
2/1/90*

C.5.8.4. The contractor shall submit to the Contracting Officer a draft . . . . :  
Beneficiary and Provider Handbook which details these activities of interest  
to the beneficiary and provider community no later than 150 calendar days  
after contract award.

C.5.8.5. No later than 180 calendar days after contract award, the . . . . .  
contractor shall establish methods for handling transitional cases, i.e.,  
those patients for whom active care is in progress on the start-work date. If  
the care provided to transitional cases would be within the scope of services . . .  
covered by this contract if initiated after the start-work date, the  
contractor shall be liable for that portion of care delivered on and after the  
start-work date for such cases. The contractor shall determine how many of  
the sixty (60) inpatient days have already been used by a beneficiary prior to  
payment of any inpatient care. The contractor shall provide a written summary  
of transition activities not later than 60 calendar days after completion of  
the mobilization phase. *Contractor shall provide methods of handling transitional*  
*Cases to the contracting officer.*

C.5.8.6. The transition plan submitted by the contractor with the proposal . . .  
shall also address the procedures that the contractor will follow upon the . . .  
completion of this contract. These procedures will be directed at minimizing  
any adverse impact which may be experienced by patients utilizing the  
services offered under this contract.

C.5.8.7. No decisions to terminate payment (because of inappropriateness or . . .  
non-necessity) for care initiated prior to the implementation date for  
delivery of comprehensive mental health services shall be made by the  
contractor without a patient (or responsible party) interview. Both the . . .  
patient and attending provider shall be notified of the purpose of the . . .  
interview at the time the interview is requested, and shall be notified of the  
decision within one (1) working day of the interview.

C.5.8.8. Only OCHAMPUS may make retroactive denials of payment for care  
initiated prior to the implementation date for delivery of comprehensive  
mental health services. If it is the opinion of the contractor that care may  
be medically or psychologically unnecessary, the contractor shall recommend to . . .  
OCHAMPUS that payment be denied, and send all supporting evidence necessary to  
arrive at a decision. At the time of its recommendation, the contractor shall  
notify the beneficiary or responsible family member and the institutional  
and/or individual provider involved.

C.5.8.9. The contractor shall provide proposed contract provider agreement . . .  
forms to the contracting officer within 120 days after award of the contract.

#### C.5.9. MARKETING PLAN

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2/1/90*

C.5.9.1. The contractor shall develop a detailed marketing plan and submit this plan to the Contracting Officer (see attach 4) for approval. The plan shall include at least information covering the following:

C.5.9.1.1. A draft of the required Federal Register notice.

C.5.9.1.2. A schedule for community meetings to be conducted by the contractor. These meetings shall be made to beneficiaries and providers within the catchment area. They shall be scheduled with sufficient frequency and availability to insure that the majority of beneficiaries are afforded the opportunity to attend.

C.5.9.1.3. A schedule of meetings with military command and military treatment facilities which shall be conducted by the contractor explaining this contract and the purpose of the demonstration and its effect on the servicemen and women and their families.

C.5.9.1.4. Persons currently in treatment who will be affected by this contract shall be provided information regarding the transition of their care to the contractor's system.

C.5.9.1.5. Information detailing the cost to the patient, claims procedures, deductibles and cost shares and the effect of the contractor's system on other CHAMPUS benefits.

C.5.10. The contractor shall meet with the current CHAMPUS FI for the mid-Atlantic region to discuss modifications of existing FI contracts. These meetings shall be scheduled by the Contracting Officer prior to the beginning date of services. The cost to modify existing FI contracts shall not be paid by the contractor.

C.5.11. Deliverables (See Attachments 4 and 5 hereto).

#### C.6. APPLICABLE REGULATIONS AND MANUALS.

C.6.1. Documents applicable to this SOU are listed below. The documents have been coded as advisory or mandatory. The contractor is only obligated to follow those coded as mandatory and only documents referenced herein. Supplements and amendments to these mandatory publications may be issued during the life of the contract. If any publication change which becomes effective during the contract period causes a change in performance within the meaning of the "Changes" clause, it will not be implemented until the contracting officer issues a change order or modification to the contract.

C.6.1.1. Mandatory:

AR 40-2, 3 Mar 78 - Army Medical Treatment Facilities and General Administration, as currently amended.

NSC Reg 40-5, Sep 87 - Ambulatory Patient Care

AR 385-10, Feb 79, Army Safety Program and NSC Supplement 1, Jun 84 to AR 385-10

AR 385-40, 1 Sep 80 - Accident Reporting and Records with NSC Supplement 1 dated 7 Aug 81

Occupational Safety and Health Administration Regulation

DOD Instruction 6010.8-R, Civilian Health and Medical Program of the Uniformed Services, Mar 86

*Current edition of*

Consolidated Standards Manual, Joint Commission on Accreditation of Healthcare Organizations, 1988a

C.6.1.2. Advisory:

AR 40-66, 1 Apr 87 - Medical Record and Quality Assurance

AR 310-15, 15 Oct 83 - Dictionary of United States Army Terms

NSC Pam 310, 1 Jun 84 - Index of NSC Command Administrative Publications

C.6.2. Unless noted otherwise, all required Army and DOD Regulations, Directives and Forms as referenced in this SOW shall be made available by the COR when requested by the contractor.

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2/4/92

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**Surveillance Plan  
Contract DADA10-89-C-0013  
Fort Bragg Mental Health Demonstration Project**

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**APPENDIX D**

**SURVEILLANCE PLAN**

## **1. INTRODUCTION**

**1.1 Purpose.** These Quality Assurance Surveillance procedures have been developed to aid the Contracting Officer's Representative (COR) in providing effective and systematic surveillance of all aspects of the contract.

## **2. RESPONSIBILITIES.**

**2.1** The U.S. Army Health Services Command (HSC) is responsible for ensuring that the mental health care services provided are satisfactory in accordance with the quality assurance specifications set forth in the contract.

**2.2** The Contracting Officer (KO), Central Contracting Office (CCO), U.S. Army Health Services Command is responsible for negotiating changes in terms, conditions or amounts cited in this contract.

**2.3** The COR is responsible for assuring contractor performance through audit, documentation and liaison with the KO.

## **3. INSPECTION PROCEDURES.**

**3.1.** Records reviews should occur at least quarterly for the duration of the project, and should contain a mix of cases, especially those requiring complex and/or extensive treatment (inpatient, residential, multiple types of treatment etc). Initially, review should probably occur monthly with an Army Child & Adolescent Psychiatrist present for clarification. Once the procedure is refined a clinician need not be present, but can review problem records after initial monitoring.

## **4. DOCUMENTATION.**

-General. Each inspection made by the COR must be documented and filed for future reference, audit and proof of inspection. Copies of documentation concerning shortfalls from expected performance levels should be forwarded to the KO within 5 workdays after the inspection has been completed. Special emphasis should be placed on any clearly unsatisfactory performance. A copy of the inspection will also be forwarded to HSC.?

1. Standard. The COR will verify that services are only being rendered to those beneficiaries residing within a 40 mile radius of Fort Bragg called the catchment area identified by zip coes.

Inspection procedures. COR will pull randomly selected case records and check zip codes.

Frequency of Inspection: Quarterly

Reference: C.1.1

2. Standard. COR will ensure that families can participate in treatment and that unnecessary separations are minimal to nonexistent.

Inspection procedures. COR will review case record to find out if family therapy is occuring and how frequently. COR will review case record to check number of client no-shows and response.

Frequency of Inspection: Quarterly

Reference: C.1.2.1

3. COR will ensure there is sufficient staff to properly perform requirements of the contract.

Inspection Procedures. Review of staff

Frequency of Inspection: Monthly at POC Meeting

Reference: C.1.3

4. Standard. COR will review hiring practices of Cardinal Mental Health and ensure that only licensed, credentialled providers are allowed to provide mental health services to clients.

Inspection Procedures. COR will randomly review credentials files. check diploma copies, indication of verification with school, must meet criteria for type of provider.

Frequency of Inspection: Quarterly

Reference: C.1.3.1 - C.1.3.14

5. Standard. COR will ensure that supervision is provided and documented for employees required to function weekly under supervision by senior level clinicians. Examples are substance abuse counselors must function weekly under supervision of senior level clinicians. Other individual Professional Providers ie., mental health counselors, foster care parents, and members of the contractor's alternative living treatment team must be under physician supervision.

Inspection Procedures. COR will verify that supervision is taking place by reviewing employment records and physician visits to the group homes.

Frequency of Inspection: Quarterly

Reference: C.1.3.9 - C.1.3.10 and C.5.3.1

6. COR will ensure that non-urgent and diagnostic services begin within a ~~one-week~~ period following request or referral.

*21 days*

Inspection Procedures. Review of client file for date of contact and first visit.

Frequency: Quarterly

Reference: C.1.4.4

7. Standard. COR will ensure that the diagnostic study shall begin within the week of referral and shall be completed and reviewed by the Treatment Team in two weeks, or less, and that the full treatment plan will be completed within 72 hours of initial contact, unless a more complex plan is needed.

Inspection Procedures. COR will review a sample of patient charts to see if the process from referral to full implementation is being completed. (Check dates)

Frequency: Quarterly

Reference: C.1.4.4

7. Standard. COR will ensure emergency services are available on a 24-hour basis and that the service provides crisis counseling and direction to the nearest emergency site. COR will also ensure that the child/adolescent can be stabilized, and that diagnostic services shall begin within 24 hours.

Inspection Procedures. COR will verify availability of services and review records of children who have received emergency/urgent services.

Frequency: Quarterly

Reference: C.1.4.5

8. Standard. COR will ensure treatment team meets contract criteria.

Inspection Procedures. The COR will review records to ensure the

treatment team consisted of a child psychiatrist, a doctoral level practicing child psychologist, and the supervisors of service components, who are fully qualified mental health professionals. COR will ensure that the MD or psychologist has signed the patient's record.

Frequency: Quarterly

Reference: C.1.4.7

9. Standard. COR will ensure that the case manager receives input from others significant to the individual client, such as his/her teacher, court counselor.

Inspection Procedures. COR will review charts for this information and discuss process with case managers.

Frequency: Quarterly

Reference: C.1.4.7

10. Standard. COR will ensure the Axis III diagnosis is completed by the physician.

Inspection Procedures. COR will review patient chart to see if Axis III diagnosis check has occurred. Also a status as to whether a physical exam is needed or additional procedures are needed.

Frequency: Quarterly

Reference: C.1.4.10

11. Standard. COR will ensure that the contractor has a program to account for property and that the property is being maintained and inventoried on an annual basis.

Inspection Procedures. COR will review property list to ensure all property is accounted for.

Frequency: Quarterly

12. Standard. COR will ensure that the cases of individuals involved in residential placement are reviewed every 14 days by the case manager and every month by the Treatment Team.

Inspection Procedures. Chart review of those individuals in residential placement.

Frequency: Quarterly

Reference: C.5.1.14

13. Standard. COR will review utilization of leased vehicles.

Inspection Procedures. Review mileage logs/trip reports.

Frequency: Quarterly (Should be briefed at POC Meeting per contract.)

14. Standard. COR will ensure that each <sup>clinical</sup> case manager be responsible for no more than 20 patients.

Inspection Procedures. COR will verify number of case managers and divide by the number of clients presently enrolled to ensure contract is being followed.

Frequency: Monthly at POC Meeting

Reference: C.5.3.1

15. Standard. COR will ensure case managers provide information to the Treatment team at least every 30 days while the patient is under treatment.

Inspection Procedures. Chart review - Team review noted

Frequency: Quarterly

Reference: C.5.3.2

16. Standard. COR will ensure that the treatment team plan does the following: Reflects the patient's clinical needs and conditions, Specifies the services necessary to meet the patients needs, Includes referrals for services that are not provided directly by the organization, Contains specific goals which the patient must achieve to attain, maintain and/or reestablish emotional and/or physical health, Shall contain specific objectives that relateto the goals, stated in measurable terms and include expected achievement dates, Shall describe the services,

activities and programs planned for the patient and specifies the staff member assigned to work with the patient, Shall describe the services, activities and programs planned for the patient and specifies the staff member assigned to work with the patient, Shall specify the frequency of treatment procedures, Shall delineate the specific criteria to be met for the termination of treatment, Shall include specific plans for the involvement of the family or significant others in the patient's treatment.

Inspection Procedures. Review progress notes

Frequency: Quarterly

Reference: C.5.4 (all)

17. Standard. COR will ensure progress notes be made for each patient which document the implementation of the treatment plan, actual treatment provided to the patient, chronological documentation of the patient's clinical course, and changes in each of the patient's conditions.

Inspection Procedures. COR will ensure that a discharge summary is entered into the patient's record within 15 days after discharge or release from care.

Frequency: Quarterly

Reference: C.5.4.5

18. Standard. COR will be responsible for the review of the contractors QA Plan and QA Program.

Inspection Procedures. COR will review written documentation of contractor's QA Plan and check for 10 pt QA Plan as per JCAHO model. Review QA Minutes.

Frequency: Monthly at POC Meeting

Reference: C.5.5.1.4

19. Standard. COR will ensure that the contractor is secondary payor for any service or supply for persons enrolled in any other insurance, medical service, or health plan except Medicaid to the extent that the service is also a benefit under the other plan.

Inspection Procedures. COR will review claims to ensure claims are first billed to other health insurance companies first.

Frequency: Quarterly

Reference: C.5.6.3

20. Standard. COR will ensure DEERS eligibility is being verified.

Inspection Procedures. COR will check to make sure this is taking place and that those who are not eligible do not receive care.

Inspection Frequency: Quarterly

Reference: C.5.6.7

21. Standard COR will ensure appeals and grievances are being handled and that they are brought to the attention of the Project Oversight Committee.

Inspection Procedures. Review of appeals and grievances.

Frequency: Quarterly

Reference: C.5.7.2

**APPENDIX E**

**SURVEILLANCE CHECKLISTS**

RECORD NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

SURVEILLANCE CHECKLIST  
ADMIN RECORD REVIEW

ITEM	YES	NO	OTHER
1. DATE SERVICE REQUESTED/REFERRAL MADE			
2. DATE OF FIRST APPOINTMENT			
3. DATE OF INITIAL STAFFING, ADMISSION ASSESSMENT			
4. DATE OF COMP. TREATMENT PLAN			
5. DATE OF TREATMENT REVIEWS			
6. LAST DATE OF SERVICE /TYPE OF SERVICE			
7. DATE OF DISCHARGE SUMMARY			
8. DATE OF PHYSICAL			
9. ZIP CODES W/I 40 MILES			
10. CASE MANAGER INFORMED			
11. PROGRESS NOTES SIGNED & STAMPED WITH INFO.			

SURVEILLANCE CHECKLIST  
POC REVIEW

ITEM (SURVEILLANCE PLAN REFERENCE)	YES	NO	OTHER
1. SUFFICIENT STAFF (3)			
2. ENOUGH CASE MGRS (17)			
3. QA MINUTES REFLECT M & E (21)			
4. KTR'S SURVEILLANCE REPORTS OBTAINED (22)			

SURVEILLANCE CHECKLIST  
CLINICAL RECORD REVIEW

ITEM (SURVEILLANCE PLAN REFERENCE)	YES	NO	OTHER
1. FAMILY PARTICIPATION (2)			
2. TRT PLANS IAW W/ KTR'S LOC PL (9)			
3. TREATMENT TEAM PLAN (19):			
a. REFLECTS CLINICAL NEEDS			
b. SPECIFIES SERVICES NECESSARY			
c. INCLUDES REFERRALS			
d. CONTAINS SPECIFIC GOALS			
e. CONTAINS SPECIFIC OBJECTIVES			
f. DESCRIBES SVCS PLANNED			
g. SPECIFIES STAFF MBR ASSIGNED			
h. SPECIFIES FREQUENCY			
i. DELINIATES TERMINATION CRITERIA			
j. INCLUDES FAMILY INVOLVEMENT PLANS			

**JAMES HEPBURN MENTAL HEALTH CLINIC**  
**CLINICAL REVIEW**

<b>ITEM</b>	<b>YES</b>	<b>NO</b>
1. Family participation documented; separations of child from family are appropriate.		
5.1 Timely initiation and completion of Rx studies and Rx plan.		
5.2 Timely and effective treatment team review and modification of treatment plan.		
5.3 Dx and individualized Rx plans are appropriate and of acceptable quality.		
6. Emergency/urgent cases are promptly identified and served and interventions are appropriate.		
7. Dx protocols are used and effective for Dx and development of Rx plan.		
8. Assigned level of care meets criteria and is appropriate to client's needs.		
9. Client received thorough assessment by senior level clinicians, which was reviewed by Rx plan.		
11. Prospective clients screened and assessed in accord w/intake screening process prior to admission.		
12. Decision regarding need for physical exam made prior to completion and implementation of Rx plan.		
14. Information regarding progress in outpatient—only reviewed by Rx team 30 days after completion of Rx plan, and every 12 visits or every 6 mos. (whichever is sooner) thereafter. Progress in outpatient Rx plan reviewed every three months.		
15. Rx plan based upon medical status and clinical needs and specifies needed services including appropriate referrals; contains goals related to emotional and physical health and measurable objectives related to goals w/expected dates for attainment; services, activities, and programs planned for client; frequency of Rx procedures, specific criteria for termination; and plans for involvement of family/significant others.		
16. Progress notes document implementation of Rx plan, clinical course, patient's response to treatment, of significant others to important events.		
17. Discharge summary within 15 days; includes complete pertinent information regarding Dx findings and progress in Rx toward achievement of goals. Includes appropriate after care plan.		
18. Physician's signatures typed/stamped w/name, degree, DEA license number.		

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Chart # \_\_\_\_\_

Type of Service:    Outpt    Case Mgmt    Emerg    In-home    Day Rx    Op Home    Res Rx    Inpt —  
(circle)

## APPROPRIATENESS OF DIAGNOSIS/TREATMENT

**I. DIAGNOSIS:** Review of the diagnostic process indicates the following:

	yes	no	NA*
A. Diagnosis is consistent with history.	_____	_____	_____
B. Diagnosis is consistent with symptoms.	_____	_____	_____
C. Diagnosis is consistent with findings.	_____	_____	_____
D. Alternative diagnosis to be considered:	_____		
E. Secondary diagnosis to be considered:	_____		

**II. TREATMENT:** Review of the Treatment (Rx) Plan indicates the following:

A.	Services are consistent with diagnosis.	_____	_____	_____
B.	Services are consistent with severity.	_____	_____	_____
C.	Services are consistent with family's needs/family's capacity to support Rx.	_____	_____	_____
D.	Length of treatment is appropriate.	_____	_____	_____
E.	Intensity of treatment is appropriate.	_____	_____	_____
F.	Alternative Rx Plan to be considered:	_____		
_____				
_____				
G.	Need for treatment supported by data.	_____	_____	_____

\* NA: Not sufficient information available to determine.

NGEN JAMES H. RUMBAUGH, JR. CHILD AND ADOLESCENT MENTAL HEALTH CLINIC  
ADMINISTRATIVE RECORD REVIEW

ITEM	YES	NO	N/A
2.d. Provider is appropriately licensed and credentialed to provide mental health services. (Reference: Contract paras. C.1.3. - C.1.3.10.)			
2.e. Provider's clinical privileges has not been limited, suspended, or revoked within five years. (Reference: Contract para. H.15.)			
13. Tx team composition meets contract requirements. (Reference: Contract para. C.1.4.7.)			
18. Client is CHAMPUS eligible under the age of 18, resides in the Fort Bragg catchment area, and has a covered DSM-III-R diagnosis. (Reference: Contract para. C.1.2.)			
19. Documented evidence shows that client eligibility has been verified using the DEERS system. (Reference: Contract para. C.5.6.7.)			
20. Only authorized mental health services outlined in para. C.5. of the contract have been provided, and mental health services excluded in para. C.5.2. have not been provided. (Reference: Contract paras. C.5. - C.5.2.)			
23. If client resides outside the catchment area, the client was seen on an emergency or space available basis, was provided only normal CHAMPUS mental health services, and the CHAMPUS fiscal intermediary for the mid-Atlantic region was properly invoiced for the cost of any services provided. (Reference: Contract para. C.5.6.5.)			
24. If transportation was provided, was it based on clinical and socio-economic need and authorized in the treatment plan? (Reference: Contract para. C.5.1.22.)			

Chart #: \_\_\_\_\_

Type of Service: ☐ Outpt ☐ Case Mgt ☐ Emerg ☐ In-home ☐ Day Tx ☐ Pt Hosp ☐ Res Tx ☐ RTC ☐ Inpt

Comments:

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

SURV\_FRM.FB (6/30/92)